SAN BERNARDINO COUNTY: DATA NOTEBOOK 2016

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Mental Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

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BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

San Bernardino County Population (2016): 2,139,570

Website for County Department of Mental Health (MH) or Behavioral Health:

http://www.sbcounty.gov/dbh/index.asp

Website for Local County MH Data and Reports:

http://www.sbcounty.gov/dbh/index.asp

Website for local MH Board/Commission Meeting Announcements and Reports:

http://www.sbcounty.gov/dbh/mhcommission/mhcommission.asp#

Specialty MH Data[1] from CY 2013: see MHP Reports folder at http://www.calegro.com/

Total number of persons receiving Medi-Cal in your county (2013): 697,392

Average number Medi-Cal eligible persons per month (2014): 633,591

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 55.1 %

Adults, 18 and over: 44.9 %

Total persons with SMI[2] or SED[3] who received Specialty MH services (2014): 30,057

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 46.9 %

Adults, 18 and over: 53.1 %

[1] Downloaded from the website, www.calegro.com. If you have more recent data available, please feel free to update this section within current HIPAA compliant guidelines. CY = calendar year.

[2] Serious Mental Illness, term used for adults 18 and older.

[3] Severe Emotional Disorder, term used for children 17 and under.

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INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the "Data Notebook?"

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services in each county. For example, the topic for our 2016 Data Notebook reviews behavioral health services for children, youth, and transition age youth (TAY)[4].

Each year, mental health boards and commissions are required to review performance data for mental health services in their county. The local boards are required to report their findings to the California Mental Health Planning Council (CMHPC) every year. Just like every other government agency that requires a report, the CMHPC creates a structured document for receiving information.

The Data Notebook is developed annually in a work group process with input from:

- the CA Mental Health Planning Council and staff members,
- CA Association of Local Behavioral Health Boards and Commissions (CALBHB),
- consultations with individual Mental Health Directors, and
- representatives of the County Behavioral Health Directors Association (CBHDA).

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates[5] to review performance data for their local county mental health services and report on performance every year,
- function as an educational resource on behavioral health data for local boards,
- enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate[6] to review and report on the public mental health system in our state.

The Data Notebook is organized to provide data and solicit responses from the mental health board on specific topics so that the information can be readily analyzed by the CMHPC. These data are compiled by staff in a yearly report to inform policy makers, stakeholders and the general public. Recently, we analyzed all 50 Data Notebooks received in 2015 from the mental health boards and commissions. This information represented 52 counties[7] that comprised a geographic area containing 99% of this

[4] See various definitions of the age ranges for these groups depending on data source, Table 2, page 8.
[5] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[6] W.I.C. 5772 (c), regarding annual reports from the California Mental Health Planning Council.
[7] Sutter and Yuba Counties are paired in one Mental Health Plan, as are Placer and Sierra Counties.

state's population. The analyses resulted in the Statewide Overview report that is on the CMHPC website at:

http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx.

Our overall goal is to promote a culture of data-driven quality improvement in California's behavioral health services and to improve client outcomes and function. Data reporting provides evidence for advocacy and good public policy. In turn, policy drives funding for programs.

Resources: Where do We Get the Data?

The data and discussion for our review of behavioral health services for children, youth, and transition age youth (TAY) are organized in three main sections:

1) Access, engagement and post-hospitalization follow-up,
2) Vulnerable populations of youth with specialized mental health needs, and
3) Mental Health Services Act (MHSA) –funded[8] programs that help children and youth recover.

We customized each report by placing data for your county within the Data Notebook, followed by discussion questions related to each topic. Statewide reference data are provided for comparison for some items. A few critical issues are highlighted by information from research reports. County data are taken from public sources including state agencies. For small population counties, special care must be taken to protect patient privacy; for example, by combining several counties' data together. Another strategy is "masking" (redaction) of data cells containing small numbers, which may be marked by an asterisk "*", or a carat "^", or LNE for "low number event."

Many questions request input based on the experience and perspectives of local board members. Board members will need to address related questions about local programs and policies in their discussion. Basic information for that discussion may be obtained from local county departments of behavioral health or mental health.

This year we present information from California Department of Health Care Services (DHCS), information about some Mental Health Services Act (MHSA)-funded programs, and data from "KidsData.org," which aggregates data from many other agencies. These and other data resources are described in more detail in Table 1, below.

[8] Mental Health Services Act of 2004; also called Proposition 63.

Table 1. Who Produces the Data and What is Contained in these Resources?

CA DHCS: Child/Youth Mental Health Services Performance Outcomes System,[9] http://www.dhcs.ca.gov	Mental health services provided to Medi-Cal covered children/youth through age 20, as part of the federally defined EPSDT[10] benefits. Focuses on Specialty Mental Health Services for those with Serious Emotional Disorders (SED) or Serious Mental Illness (SMI).
CA DHCS: Office of Applied Research and Analysis (OARA)	Substance Use Disorders Treatment and Prevention Services for youth and adults. Annual reports contain statewide data, some of which is derived from data entered into the "Cal-OMS" data system.
CA DOJ: Department of Justice yearly report on Juveniles. Data at: www.doj.ca.gov	Annual data for arrests of Juveniles (<18) for felonies, misdemeanors, and status offenses, with detailed analysis of data by age groups, gender, race/ethnicity, county of arrest, and disposition of cases.
External Quality Review Organization (EQRO), at www.CALEQRO.com	Annual evaluation of the data for services offered by each county's Mental Health Plan (MHP). An independent review discusses program strengths and challenges; highly informative for local stakeholders.
KidsData.Org, A Program of Lucile Packard Foundation for Children's Health, see www.KidsData.org	Collects national, state, and county statistics. CA data are from DHCS, Depts. Of Public Health, Education, and Justice, Office of Statewide Health Planning and Development, "West-Ed," and others.
Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov	Independent data reports and links to other federal agencies (NIMH, NIDA). Example: National Survey on Drug Use and Health (NSDUH), which covers mental health, alcohol and drug use in adults and youth with analysis of needs and how many receive services.
County Behavioral Health Directors Association of California (CBHDA); see www.cbhda.org/	An electronic system (eBHR) to collect behavioral health data from CA counties for reporting in the "Measures Outcomes and Quality Assessment" (MOQA) database.

[9]See recent reports at: www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx, and http://www.dhcs.ca.gov/services/MH/Documents/POS_StatewideAggRep_Sept2016.pdf.

[10] EPSDT refers to Early, Periodic Screening, Diagnosis and Treatment. These federally-defined services are available to Medi-Cal covered children and youth from birth through age 20.

How Do the Data Sources Define Children and Youth?

Although it may be common to refer broadly to children and youth collectively as "youth," discussions of data require precise definitions which may differ depending on the information source and its purpose. For example, "minor children," also called juveniles, are defined by the legal system as those under the age of 18. Others may define subcategories by age to describe psychological or biological[11] stages of development. Many systems are based on requirements for state reports to the federal government. Ideally, we might like to have all data broken down by the same age groups to simplify discussion. Unfortunately, that is not possible because we do not have access to the raw data sets (nor the resources) for such a major re-analysis. Here, we use the age breakdowns provided by the various public data sources that are available to us.

Table 2. Categories used by Different Data Resources for Children and Youth

Category	**EPSDT MH Services**	**CA EQRO**	**MHSA Programs**	**JUSTICE System**	**SMHSA, NSDUH, Federal datasets**
Children (or Juveniles)	0-5	0-5	0-15	0-17	
	6-11	6-17	--	--	6-11
	12-17 (Youth or 'Teens')	--	--	--	12-17
Adults	18-20	>18	(varies)	>18	>18
Transition Age Youth (TAY)	N/A[12]	16-25	16-25	N/A	16-25 (or one alternative used is 18-25 = young adults).

[11] Biological development loosely refers to pediatrics-defined stages of physical, cognitive and emotional growth.
[12] N/A means not applicable, because this category is not available under this system or data source.

How Can Local Advisory Boards Fulfill their Reporting Mandates?

What are the reporting roles mandated for the mental health/behavioral health boards and commissions? These requirements are defined in law by the state of California.

Welfare and Institutions Code, Section 5604.2 (a)

The local mental health board shall do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.

(2) Review any county agreements entered into pursuant to Section 5650.

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) ***Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.***

(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

The structured format and questions in the Data Notebook are designed to assist local advisory boards to fulfill their state mandates, review their data, report on county mental health programs, identify unmet needs, and make recommendations. We encourage all local boards to review this Data Notebook and to participate in the development of responses. It is an opportunity for the local board and their supporting public mental health departments to work together on the issues presented in the Data Notebook.

This year we present information about important topics for children and youth. Each section is anchored in data for a current topic, followed by discussion questions. A final open-ended question asks about *"any additional comments or suggestions you may have."* Ideas could include a program's successes or strengths, changes or improvements in services, or a critical need for new program resources or facilities. Please address whatever is most important at this time to your local board and stakeholders and that also may help inform your county leadership.

We were very impressed with the level of participation in 2015, having received 50 Data Notebooks that represent data from 52 counties. Several examples of good and even exemplary strategies were evident in these reports. At least 22 local boards described a process that was largely collaborative in that board members worked with county staff to produce the Data Notebook. In several counties, the responses were developed by an *ad hoc* committee or special work group of the local board and staff and then presented to the local board for approval. In other counties, the responses in the Data Notebook were developed by staff and presented to the local boards for approval. In a few counties, responses were prepared by staff and submitted directly to the CMHPC.

In an August 25, 2015 letter, the County Behavioral Health Directors Association (CBHDA) endorsed the expectation that "the process of gathering this data should be collaborative between the Advisory Boards and the Mental Health Plans (MHPs)." They also stated that "then the process would be more natural to the actual dynamic that exists in the counties." The California Mental Health Planning Council fully supports these statements and finds them consistent with the spirit and intent of the statutes.

This year we encourage every local board to look at and participate in developing the responses to questions outlined in the Data Notebook. We hope this Data Notebook serves as a spring-board for your discussion about all areas of the mental health system, not just those topics highlighted by our questions.

The final page of this document contains a questionnaire asking about the strategies you employ to complete this year's Data Notebook. Please review these in advance, before beginning this work.

Thank you very much for participating in this project.

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ACCESS TO SERVICES: Youth, Children, and their Families/Caregivers

Access: Outreach and Engagement with Services

One goal of the Mental Health Services Act (MHSA) is to promote outreach to engage all groups in services, including communities of color and LGBTQ[13] youth. If children, youth or their families are not accessing services, we may need to change our programs to meet their mental health needs in ways that better complement their culture or language needs. These values also guide the county mental health plans that provide specialty mental health services (SMHS). These services are intended for those with serious emotional disorders (SED) or serious mental illness (SMI).

As you examine data on the following pages, consider whether your county is serving all of the children and youth who need specialty mental health services. The standard data collected does not provide much detail about all the cultural groups that live in each county. The rich diversity of California can present challenges in providing services in a culturally and linguistically appropriate manner, as we have residents with family or ancestors from nearly every country.

From data the counties report to the state, we can see how many children and youth living in your county are eligible for Medi-Cal and how many of those individuals received one or more visits for mental health services. There are several ways to measure service outreach and engagement that help us evaluate how different groups are doing in their efforts to obtain mental health care.

The simplest way to examine the demographics of a service population is to look at "pie chart" figures which show the percentage of services provided to each group in your county. Figure 1 on the top half of the next page shows the percentages of children and youth from each major race/ethnicity group who received one or more SMHS visits during the fiscal year (FY). The lower half of the figure shows the percentage of each age group that received specialty mental health services (SMHS, in the graphs and tables). The gender distribution is not shown because it is fairly stable year over year across the state as a whole: about 45% of service recipients are female and about 55% of recipients are male.

Following Figure 1, more detailed data are shown in Figures 2 and 3, describing the Medi-Cal eligible population of children and youth, the percentages of each group that received specialty mental health services, and changes in those numbers over time for the fiscal years 2010-2011 through 2013-2014.

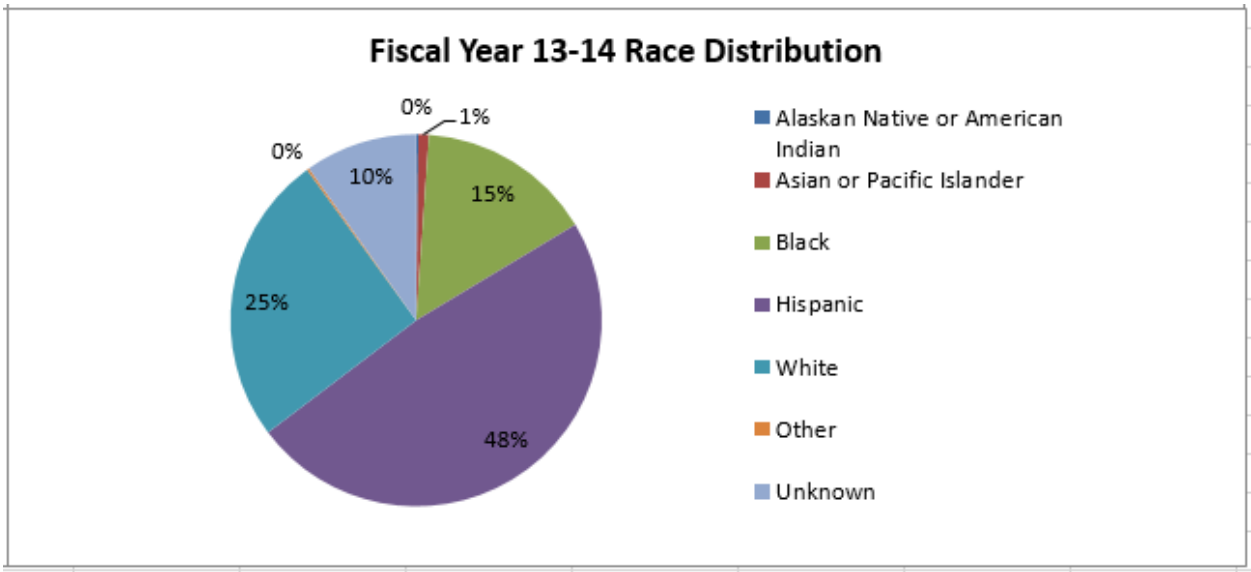
[13] Lesbian, Gay, Bisexual, Transgender, Questioning/Queer.

Figure 1. Demographics for Your County: San Bernardino (FY 2013-2014)

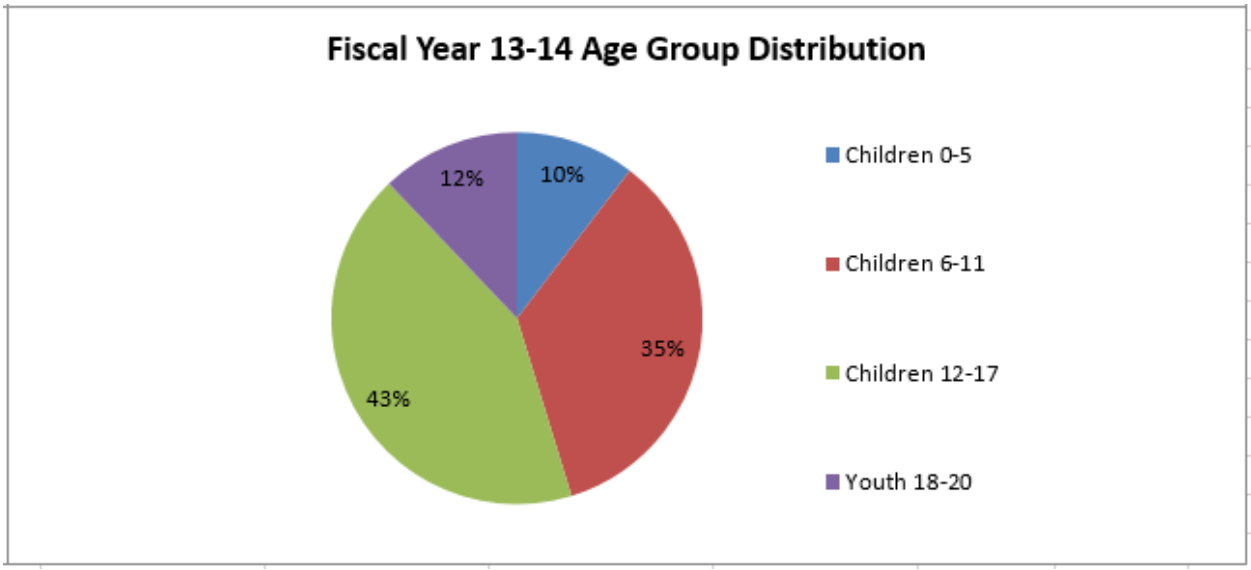
Unique numbers of children and youth who were Medi-Cal eligible: **434,625**

Of those, the numbers of children and youth who received one or more Specialty Mental Health Services (SMHS): **16,135**.

Top: Major race/ethnicity groupings of children and youth who received one or more specialty mental health services during the fiscal year.



Below: Age groups of children and youth who received one or more specialty mental health services.



Client access and engagement in services is a complex issue and is somewhat difficult to measure. One way to measure client engagement is "penetration rates." Service penetration rates measure an individual's initial access and engagement in services provided by the local mental health plan. Figure 2 on the next page shows data that illustrate two common ways to measure penetration rates:

- One way is to count how many children and youth came in for at least one service during the year, as shown in the data in the top half of figure 2. These data may provide information about outreach and at least initial access to services for child/youth clients of different ages and race/ethnicity groups.

- Another way to measure the penetration rate is to consider how many had sustained access to services for at least five or more visits, as shown in the data in the lower half of figure 2. This is sometimes referred to as the "retention rate." This measure is often used as a proxy (or substitute) for client engagement. Here, we measure how many came in for five or more services during the year.

Figure 2: in the table at the top of the page, the first column of numbers show how many children/youth received at least one specialty mental health service. The second column shows the number who were certified Medi-Cal eligible in each group. The final column at the right shows service penetration rates, which are calculated by dividing the number who received services by the total number who were Medi-Cal eligible.

The second table of Figure 2 shows data for those with more sustained engagement in accessing services. The first column of numbers show how many children/youth received five or more services during the fiscal year. The middle column, showing numbers who were Medi-Cal eligible, is identical to the middle column in table in the upper half of the page. The column at the far right shows the percentage in each group who received five or more services. Clearly, these numbers are much smaller than the corresponding rates in the data table shown above.

Figure 3 on the subsequent page shows a set of bar graphs: these graphs show changes over four fiscal years in service penetration rates by race/ethnicity, for children and youth who had at least one visit for services. Each group of bars shows the changes over time for one major race/ethnicity group. The final bar in each group illustrates the time point for FY 2013-2014 that was presented in more detail in figure 2. The "take home story" of figure 3 is the overall trend leading up to the most recent year's data. Please note that these data show the trends that occurred in the years following passage of the Affordable Care Act (2010).

Figure 2. Data Tables for SMHS Visits and Service Penetration Rates
Your County: San Bernardino (FY 2013-2014):

Top: Children and youth who received at least one specialty MH service during year.

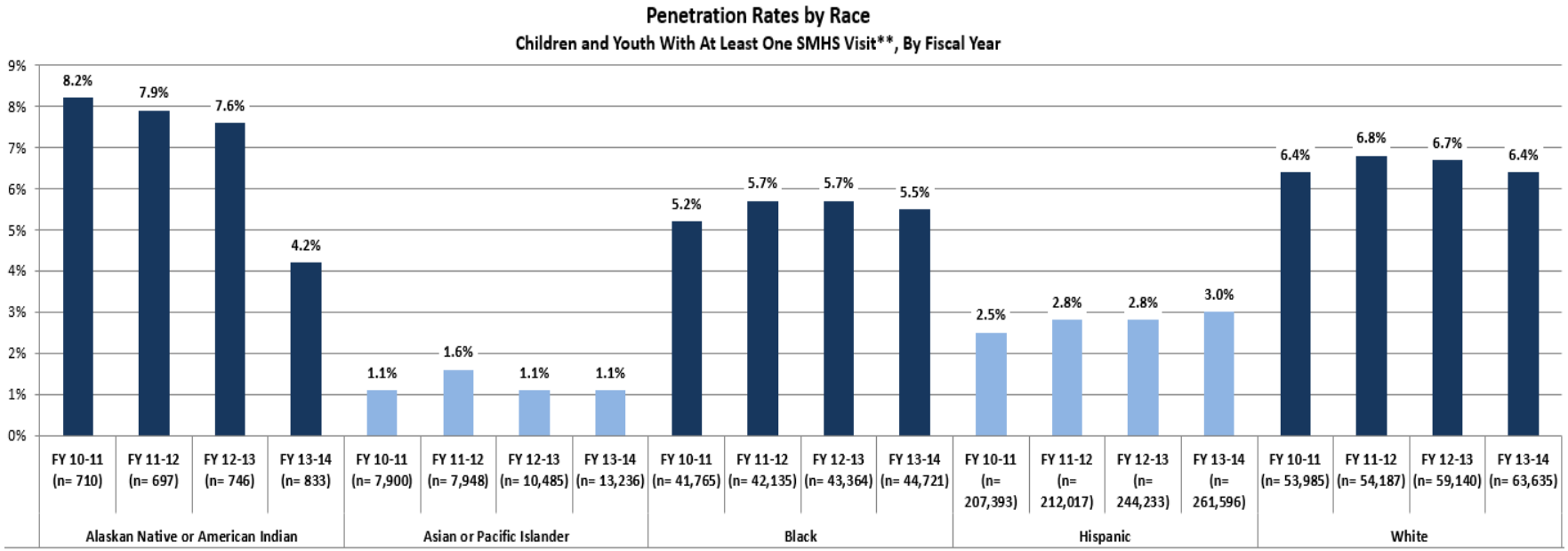
	FY 13-14		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**16,135**	**434,625**	**3.7%**
Children 0-5	1,684	133,947	1.3%
Children 6-11	5,622	127,562	4.4%
Children 12-17	6,880	113,570	6.1%
Youth 18-20	1,949	59,546	3.3%
Alaskan Native or American Indian	35	833	4.2%
Asian or Pacific Islander	151	13,236	1.1%
Black	2,469	44,721	5.5%
Hispanic	7,787	261,596	3.0%
White	4,075	63,635	6.4%
Other	31	2,176	1.4%
Unknown	1,587	48,428	3.3%
Female	6,613	215,525	3.1%
Male	9,522	219,100	4.3%

Below: Children and youth who received five or more specialty MH services during year.

	FY 13-14		
	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**11,255**	**434,625**	**2.6%**
Children 0-5	1,143	133,947	0.9%
Children 6-11	4,080	127,562	3.2%
Children 12-17	4,844	113,570	4.3%
Youth 18-20	1,188	59,546	2.0%
Alaskan Native or American Indian	20	833	2.4%
Asian or Pacific Islander	94	13,236	0.7%
Black	1,698	44,721	3.8%
Hispanic	5,361	261,596	2.0%
White	2,904	63,635	4.6%
Other	24	2,176	1.1%
Unknown	1,154	48,428	2.4%
Female	4,496	215,525	2.1%
Male	6,759	219,100	3.1%

Figure 3. Changes Over Time in Service Penetration Rates by Race/Ethnicity, for Children/Youth with at Least One Specialty Mental Health Service During Fiscal Year. (FY 10-11 through FY 13-14).

Your County: San Bernardino



Understanding the changes observed above should take into account the expansion of the total Medi-Cal eligible population, which resulted in a statewide increase of nearly 12% in FY12-13 relative to the previous year. The expansion occurred in stages during 2011 to 2013 as the state began to implement the changes mandated in the federal Affordable Care Act (2010). Families with incomes up to 138% of the federal poverty level became eligible for Medi-Cal. Also, children and families previously enrolled in "CHIP," federal Children's Health Insurance Program transitioned to Medi-Cal.

** **^** = Data redacted for privacy due to small numbers.

Please consider the following discussion items after examining the data above regarding access and engagement in mental health services.

QUESTION 1A:

Do you think the county is doing an effective job providing access and engagement for children and youth in all of your communities?

Yes X No____. If yes, what strategies seem to work well?

The San Bernardino County Department of Behavioral Health (SB-DBH) is effectively providing access and engagement for children and youth through the following: prevention and early intervention, including partnerships with schools; the expansion of Full Service Partners (FSP) services; substance use disorder prevention, screening and services; collaboration with the courts and justice system; and community-based programs.

SB-DBH data reflecting our penetration rates for fiscal year 2013-2014 (FY 13/14) are provided as additional context to the State claims data, and the SB-DBH strategies are then detailed. In review of SB-DBH's penetration rate for various age groups, the following mental health rates were observed in FY 13/14. It is important to note that the rates below reflect only those who were Medi-Cal beneficiaries, though SB-DBH also served non-Medi-Cal beneficiaries.

SB-DBH Children and Youth – Mental Health Services FY 13/14					
	Medi-Cal Beneficiaries (July 2014)	**Medi-Cal Consumers**	**Non-Medi-Cal Consumers**	**All Consumers**	**Medi-Cal Penetration Rate**
Total	**335,391**	**16,543**	**1,998**	**18,541**	**4.9%**
0-5 Years	103,769	912	80	992	0.09%
6-11 Years	104,675	4,681	336	5,017	4.5%
12-17 Years	92,053	7,143	700	7,843	7.8%
18-20 Years	34,894	3,807	837	4,644	10.9%

The penetration rate is Medi-Cal consumers served compared to total Medi-Cal Beneficiaries in a sample month, July 2014.

Medi-Cal Beneficiaries is based on State list of everyone eligible for Medi-Cal for FY 13/14

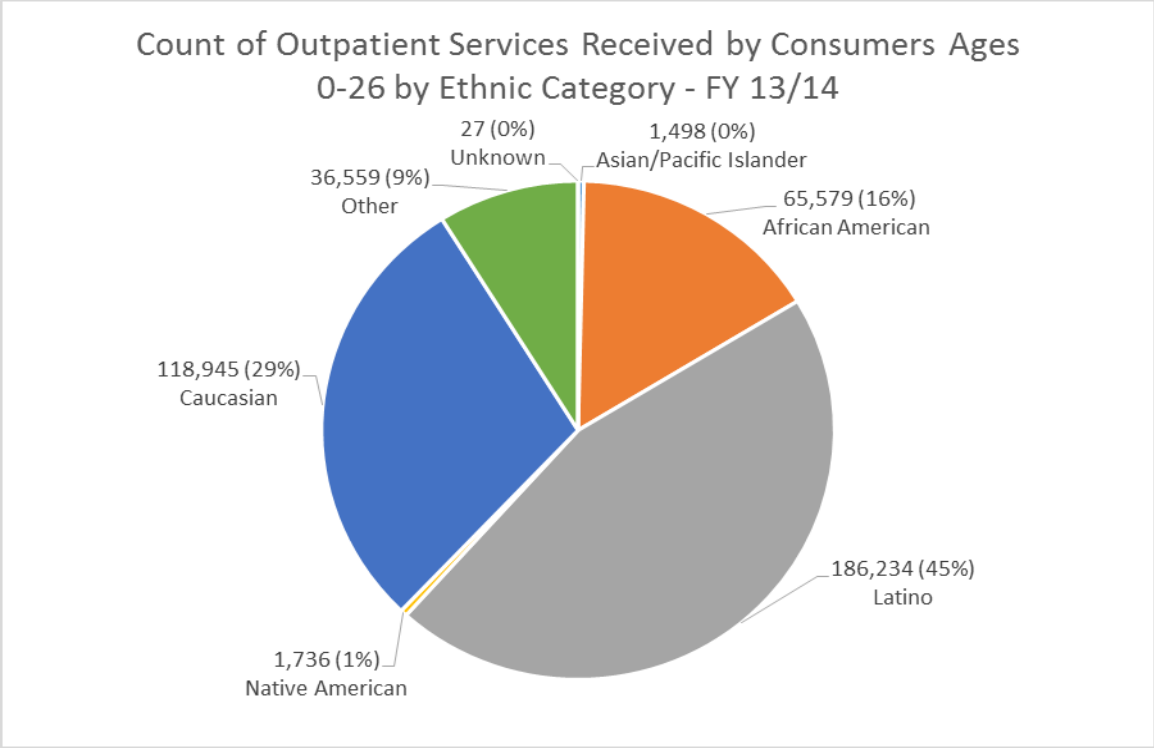
Medi-Cal Consumers are the actual clients served by SB-DBH during the FY 13/14 year.

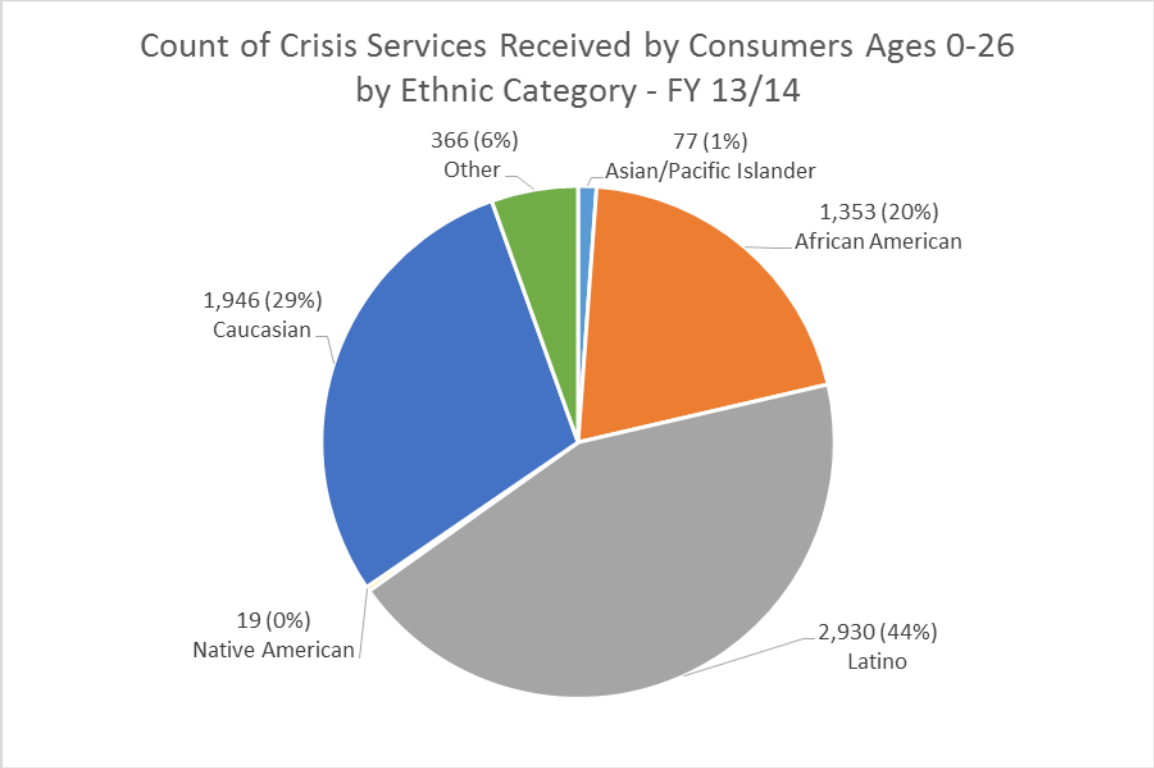
Non-Medi-Cal Consumers are individuals served who were not enrolled at the time of service and are not included in the penetration rate.

Additionally, minors served by the Community Crisis Response Team (CCRT) in FY 13/14 in all regions (East Valley, West Valley, High Desert and Morongo Basin):

Crisis Services Provided by Age Group	Crisis Outreach to Minors in FY 13/14
Ages 1-12	574
Ages 13-17	1,766
Ages 18-25	761

The following data displays access to services by ethnic groups to determine if there was a disparity between the use of outpatient clinic visits and crisis services. In fact, the rates of utilization between ethnic groups were very similar across outpatient and crisis services.





For children and youth, the primary strategies focus on increased collaboration with other agencies such as Local Education Agencies (LEAs), Child and Family Services (CFS), Probation, and Preschool Services while increasing the capacity for services through expansion of programs. The expansions that have occurred with programs are fiscally feasible due to the efficient leveraging of multiple funding sources, including the Mental Health Services Act (MHSA) and partner agency funding. For example, to create better access and services for the 0-5 population, SB-DBH has implemented programs by blending the funding sources of Early Periodic Screening, Diagnosis and Treatment (EPSDT) Medi-Cal, Mental Health Services Act – prevention and early intervention (MHSA – PEI) funds, and funds from First 5 of San Bernardino. The two programs targeting this population work closely with Children's Network, CFS, and Preschool Services to facilitate an easy referral process. In FY 13/14, 1,684 children aged 0-5 were provided at least one service. For FY 15/16, these two programs served slightly more than 3,300 children from this population.

Additionally, SB-DBH is working closely with school districts that allow SB-DBH practitioners into their district based on the SB 3832 mandate that allows schools to bill for Medi-Cal services. One example of a braided funding program is the implementation of a Medi-Cal certified mental health clinic operated by the LEA or the incorporation of LEA funding within a local clinic. This has been implemented with six LEAs within our county and there is ongoing dialogue with other LEAs. The districts determine the level of engagement with SB-DBH providers. As we establish services district-by-district, we increase our outreach and continue to seek partnerships with school districts across the County.

SB-DBH finds the following strategies work well to provide access and engagement to children and youth through a variety of services and partnerships. Example services using these strategies are provided to illustrate the strategies in practice.

Strategy #1 – Prevention and early intervention, including partnerships with schools

Strategy #2 – Expansion of Full Service Partnership (FSP)

Strategy #3 – Substance use disorder treatment, prevention, screening, and services

Strategy #4 – Collaboration with courts and justice system

Strategy #5 – Community-based programs

Strategy # 1 - Prevention and early intervention, including partnerships with schools:

1a) The Student Assistance Program (SAP) is a school-based approach to providing focused services to diverse students and their families who are in need of prevention education and early interventions for substance abuse, mental health, academic, emotional and social issues. The SAP program aims to minimize barriers to learning, support students in developing academic and personal successes, reduce suicide rates, reduce incidences of

mental illnesses and shorten the duration of untreated illnesses. Identified students receive appropriate interventions at school or through referrals. Services can include: group and individual counseling, anger management classes, or curriculum-based psychosocial education. A portion of the program is dedicated toward building the capacity of schools to appropriately identify and respond to student behavioral health needs. Partnering with schools improves access and engagement for children and youth who may not have other access options.

1b) The Low Income First Time mother's program provides in-home visitation services to low-income mothers, which include transition-aged youth, during pregnancy and continuing through their children's second birthday. The program seeks to improve pregnancy outcomes for mothers while improving infants' health and development. LIFT provides screenings and assessments, case management, linkage and referrals, and education on topics that include parenting and healthy nutrition. Providing this service in the families' homes helps to increase access to services and resources for children and youth.

1c) The Preschool Prevention and Early Intervention (PEI) Program provides mental health support for diverse preschool children and training for their parents and teachers. The goal of this program is to prevent and treat young children's behavioral problems and promote their social, emotional, and academic competences. Services are provided on site at over 39 State and Head Start Preschools throughout the county creating greater access to services for children and their families. Services provided include screenings, assessments, linkage, and referrals to appropriate resources. This program improves early access and engagement to young children by partnership with preschools.

1d) The Resilience Promotion in African American Children program improves access and engagement by providing prevention and early intervention services to African American children/youth and their families by incorporating African American values, beliefs, and traditions in mental health educational programs. This program promotes resilience in African American children in order to mediate the development of mental health and/or substance abuse disorders. Services are offered at school site locations and focus on the strengths of the African American community. The program includes curriculum-based education, cultural awareness activities, conflict resolution training, educational workshops, on-going weekly interventions, career-related presentations, parent support/education, and linkage to additional resources. Educational workshops and group presentations are conducted to assist African Americans in feeling comfortable in seeking mental health services from staff that are knowledgeable and capable of identifying needs and solutions for African American families and individuals.

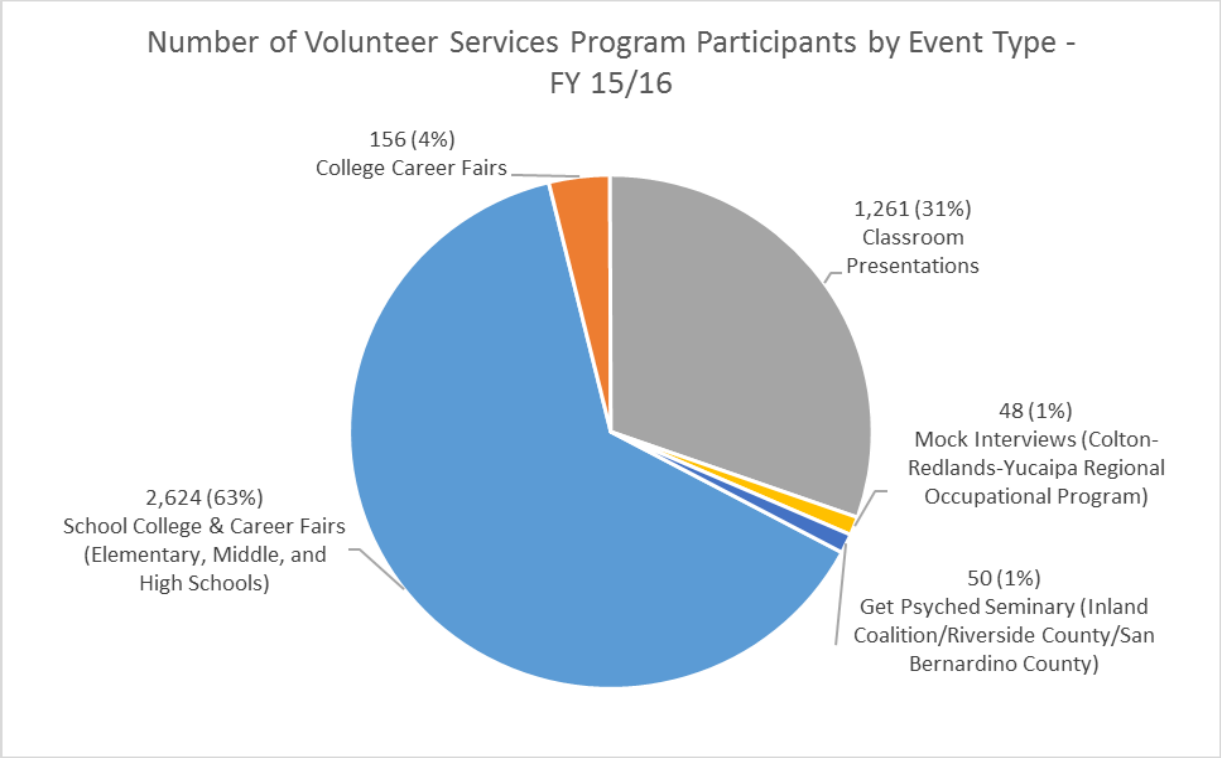
1e) The National Curriculum and Training Institute (NCTI) Crossroads® Education targets access and engagement for children and youth who are at risk of or involved in the

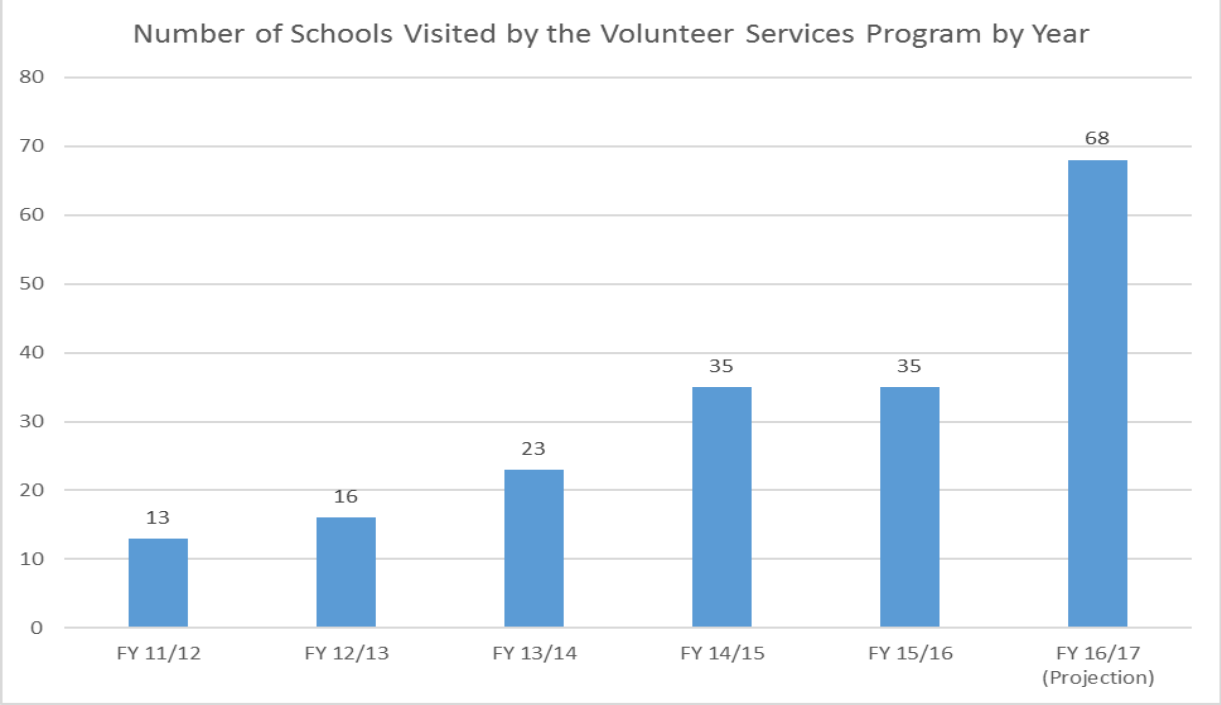
juvenile justice system. NCTI is a curriculum-based education strategy that fosters positive, pro-social behavior in children and transitional age youth. NCTI providers collaborate with community organizations, school, and Family Resource Centers (FRC) to provide access to services and promote a positive learning environment to diverse populations. NCTI is a curriculum-based education strategy delivered according to unique methods that foster positive, pro-social behavior in children and youth with emphasis on prior offenders. This program employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process. The curriculum focuses on the relationship between values, attitudes, and behaviors as they relate to the decision making process. Class topics include: anger management, life skills, parent education, substance abuse prevention, gang involvement, truancy intervention, and graffiti prevention. Parenting classes are offered to the families of the children and youth participating in the program.

1f) The Military Services and Family Support program provides access and engagement via mental health services to military families, which includes outreach and engagement at schools on and near military bases and other communities identified as having a higher military population. Program staff participate in a variety of school-sponsored events where they engage transition-aged students and provide information on mental health and available services, stigma and discrimination reduction, and suicide prevention.

1g) Crisis Services provides mobile, urgent access and engagement by responding to calls from schools (elementary, middle, high school and colleges) all over the county in response to students presenting with behaviors that are concerning for school staff demonstrating a psychiatric crisis. The CCRT staff respond to and assess the level of acuity to the child or youth in crisis, provide crisis intervention, and, if needed, link the child or youth to a hospital or to outpatient services, which always involves a parent or guardian. CCRT offers presentations for school staff/counselors and students to educate on mental health issues and needs. CCRT and TEST continue to maximize the program's resources for crisis intervention, so with additional staffing, more could be done with children and adolescents in providing access and engagement.

1h) DBH runs and administers a robust volunteer program to provide internships and volunteer opportunities for career development in the behavioral health professions. The following charts provide an overview as to the outreach to schools and institutions of higher learning through the workforce development Volunteer Services Program Activity:


Number of Volunteer Services Program Participants by Event Type - FY 15/16
156 (4%)
College Career Fairs
1,261 (31%)
Classroom Presentations
48 (1%)
Mock Interviews (Colton-Redlands-Yucaipa Regional Occupational Program)
50 (1%)
Get Psyched Seminary (Inland Coalition/Riverside County/San Bernardino County)
2,624 (63%)
School College & Career Fairs (Elementary, Middle, and High Schools)


Number of Schools Visited by the Volunteer Services Program by Year
80
70
60
50
40
30
20
10
0
13
16
23
35
35
68
FY 11/12
FY 12/13
FY 13/14
FY 14/15
FY 15/16
FY 16/17 (Projection)

Strategy #2 - Expansion of Full Service Partnership (FSP):

Prior to the implementation of MHSA, DBH partnered with Children and Family Services (CFS) and Probation to provide wraparound, children's intensive services, Therapeutic Behavioral Services (TBS), and other intensive care for dependents involved with the foster and justice systems. Through MHSA, DBH has been able to expand this care to more than the dependency population to support the needs of children, youth, and families. Due to on-going community needs and new legislation, such as Continuum of Care Reform (CCR), DBH is continuing to make efforts to expand children and youth FSPs. An example of the expansion of the children's Full Service Partnership (FSP) program is Comprehensive Children and Family Support Services (CCFSS), which was accomplished through multiple Request for Proposals (RFPs) during FY 15/16. This expansion of service resources proactively addressed the system-wide increase needed to effectively improve access and engagement to higher needs children and youth and to implement CCR. There are four unique programs within CCFSS, and the expansions were accomplished through targeted use of MHSA funds and collaboration with CFS to provide additional funding. Although current utilization rates for FY 16/17 are not complete, the funding increases have more than doubled an in-home FSP (i.e., Success First/Early Wrap) and expanded a residential FSP to 11 group homes, which are transitioning to Short Term Residential Therapeutic Programs (i.e., Children's Residential Intensive Services – ChRIS). The success of these programs will be due, in large part, to the collaborative nature in San Bernardino. Both in the development of the RFPs and in the implementation and monitoring of services, SB-DBH, CFS, and Probation staff work together on a regular basis.

Strategy #3 – Substance use disorder treatment, prevention, screening, and services

The San Bernardino County Department of Behavioral Health Alcohol and Drug Services (SB-DBH ADS) implements multiple strategies to improve access and engagement for children and youth who require substance use disorder services.

3a) Alcohol and Other Drug (AOD) Counselors are placed in programs throughout the system of care to be able to identify co-occurring substance use disorders at any point an individual comes into contact with SB-DBH, so they are ensured linkage to needed and appropriate services. For programs that do not have direct access to AOD Counselors, staff are trained to identify co-occurring substance use disorders and if identified to refer the individual to the Screening Assessment and Referral Center for a full assessment and admission to the proper level of treatment.

3b) Prevention services are developed to align with the Strategic Prevention Framework (SPF) that is approved by the Department of Health Care Services. The SPF outlines the County's approach to substance use disorder prevention services through the use of community-based environmental prevention strategies. Prevention interventions are

designed to assist individuals in developing intentions and skills to act in a healthy manner, others focus on creating environments that support healthy behavior. SB-DBH ADS targets Environmental Prevention efforts at youth and young adults through age 25, as this target population is at a higher risk for substance misuse. This improves access and engagement by raising awareness of substance use disorders and services.

3c) SB-DBH ADS enhances access and engagement by providing new and unique services to children and youth such as the Youth Residential Treatment and Withdrawal Management, which is one of the few Youth SUD Residential Treatment options in the State. SB-DBH ADS is currently in the development phase for Intensive Outpatient Treatment for youth. This will complete the continuum of care so that all youth in need of SUD treatment can enter the system of care at a level that meets their needs and move down or up within those levels to achieve recovery.

3d) Since 2003, the SB-DBH ADS partnered with community based organizations to organize and present a Recovery Happens Event to improve access and engagement to substance use disorder services. Every September, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors Recovery Month to increase awareness and understanding of behavioral health and substance use issues and celebrate people who recover. SB-DBH ADS solicits organizations throughout the community to be part of the event, including members of the TAY programs, treatment programs, and hundreds of volunteers from high schools around the County. This event brings awareness and assists in reducing stigma associated with substance use disorders. Also, student volunteers provide positive feedback that it gives them the opportunity to assist those in need and opens their eyes to the dangers of underage drinking and substance misuse.

Strategy #4 - Collaboration with courts and justice system

4a) The Forensic Adolescent Services Team (FAST) provides access and engagement to all Probation youth detained in a Juvenile Detention and Assessment Center (JDAC). Each youth receive a full clinical assessment within 14 days of detainment, crisis stabilization services, and screening for referrals to community resources upon release from the JDAC. The Behavioral Health Juvenile Justice Program (JJP) in collaboration with the San Bernardino County Juvenile Court, District Attorney's Office, Probation, Public Defender's Office, and other partnering agencies participate in three juvenile specialty courts. Staff attend multi-disciplinary team (MDTs) meetings prior to each court proceeding to discuss youth treatment needs and progress in the program. Behavioral Health staff provide case management to assist youth in successfully reintegrating back into the community. The following juvenile specialty courts that JJP is involved in include:

- Court for the Individualized Treatment of Adolescents (CITA)
- Juvenile Mental Health Court (JMHC)
- Juvenile Drug Court (JDC)

i. **Court for the Individualized Treatment of Adolescents (CITA):** Youth in the juvenile justice system who have been identified with significant behavioral health issues are referred to the CITA for court-ordered treatment. The youth are linked with outpatient psychotherapy and psychiatric care. The goal is to link these youth with appropriate behavioral health treatment in the community. Additionally, the youth receive close supervision by the Probation Department, as well as monthly court oversight. The program requires active parental involvement.

ii. **Juvenile Mental Health Court (JMHC):** JMHC assists in the timely resolution of juvenile delinquency cases where the issue of legal competency has been raised and in those matters where the behavioral health or developmental disability of the youth has created significant treatment or placement issues.

iii. **Juvenile Drug Court (JDC):** JDC is an eight-month program that involves frequent court appearances, frequent drug testing, and group, individual, and family counseling.

4b) The Child and Youth Connection (CYC) program connects children with severe emotional disturbances to medically necessary care and treatment. This program is a collaborative between SB-DBH, the Juvenile Public Defender's Office, Children's Network, Child and Family Services (CFS), and local contract providers. The CYC program is comprised of several components to offer a wide array of specialty services to meet the unique access and engagement needs of children and youth. The Screening, Assessment, Referral, and Treatment (SART) and Early Identification and Intervention Services (EIIS) components provides comprehensive treatment services to children ages 0-5 who experience social, physical, behavioral, developmental, and/or psychological issues. Services include behavioral health screenings, individual and family therapy, rehabilitative services, and intensive care coordination. A third component, administered through the Juvenile Public Defender's Office, offers in-home screenings, psychosocial assessments, drug assessments, referrals, consultations regarding behavioral health, education, placement needs, and other supportive services to children and transition-aged youth involved in the juvenile justice system. The Juvenile Justice Community Reintegration (JJCR) helps ensure access and engagement of youth detained in JDAC for their time after release. JJCR met 95% of the Substance Abuse and Mental Health Services Administration (SAMHSA) goal by providing 243 clients with intensive case

management services in FY 13/14. Over half of the youth completed an appointment or attended an activity they were referred to. The Juvenile Justice Program also provides substance use disorder prevention services and linkage to treatment providers for in-custody and out-of-custody youth ages 12-17.

Strategy #5 – Community based programs

5a) In partnership with CFS, the Coalition Against Sexual Exploitation (CASE) provided access and engagement to sexually exploited children and youth. CASE provides prevention services to over 40 youth and Transition-Aged Youth (TAY) in FY 13/14. CASE also provided training and resources to 4,175 community members during the same year, further improving access and engagement through community education and awareness.

5b) SB-DBH partners with many Faith-based Organizations (FBO) to improve collaboration and awareness of behavioral health needs and services. People and families with behavioral health concerns often go to their faith communities for help first. By partnering with these communities, access and engagement is improved for children and youth by giving skills and awareness to their families and communities. Examples of this partnership include providing Mental Health First Aid training at FBOs, working with the California Mental Health Friendly Communities institute to provide training to FBOs, and having representatives from multiple faiths participate in the SB-DBH Spirituality Subcommittee and subcommittee events. FBO and community partners of SB-DBH include:

- Faith Advisory Council on Community Transformation (FACCT)
- Inland Empire Concerned African American Churches (IECAAC)
- Children and Family Services Faith in Motion
- The First Baptist Church of Redlands
- Congregation Emanu El
- Mount Zion Baptist Church
- Diocese of San Bernardino
- Christian Counseling Services
- Azusa Pacific University
- The Khmer Buddhist Society
- Loma Linda University Seventh Day Adventist Church
- Fuller Theological Seminary

5c) The Community Health Workers (CHW) and *Promotes de Salud* (PdS) programs provide access and engagement services to members of all ages through field-based outreach. CHWs and PdS staff come from the communities in which they work, which are

culturally-diverse and include Latino, Asian Pacific Islander, African American, and LGBTQ populations. Services include education and promotion of behavioral health prevention and wellness as well as linkage to behavioral health resources. Services are provided in participants' homes as well as at community and faith-based organizations, creating greater access for children and youth.

5d) The Family Resource Centers improve access and engagement by offering various culturally and linguistically competent services in different communities throughout the region, increasing the likelihood that community members will use the services. Several Family Resource Centers are co-located at various school grounds, which allows for easier access to services by children and youth. The program provides community outreach and educational services, screenings and assessments, case management, and linkage and referrals.

5e) CFS has identified that postpartum depression is a major risk factor for children to be removed from a home. SB-DBH and CFS partner to identify parents early for potential postpartum depression. This involves bi-annual trainings for clinicians, social workers, psychiatrists, pediatricians to identify signs of post-partum depression in parents. Family Resource Centers (FRC) help identify and screen the cases and refer into appropriate levels of care and provide support/group therapy.

5f) General mental health outpatient programs provided by the San Bernardino County Department of Behavioral Health, along with contracted agencies, are a primary access door for people of all ages throughout the community. These programs are committed to developing culturally and linguistically competent services. Behavioral health services include crisis intervention, assessment and referral, individual and group therapy, medication support, case management, and drug and alcohol psycho-educational workshops. Services are provided for children, youth, adults and older adults.

QUESTION 1B:

What strategies are directed specifically towards outreach and engagement of transition-aged youth in your county? Please list or describe briefly.

Most of the strategies described in Question 1A also provide access and engagement to transition aged youth (TAY), including intensive services, such as FSPs, wraparound, and TBS. Additional strategies specific to TAY in our County direct outreach activities to areas of risk for TAY population, particularly homelessness, substance abuse, crisis services, and justice involvement. Further, there are important nexus points with other SB-DBH services in regards to TAY: Crisis Services are focused on suicide prevention with this age group and responsiveness to behavioral health emergencies in the schools. CCRT works with TAY youth to intervene and connect them

to care during a crisis. For TAY who have experienced incarceration, the Juvenile Justice Programs refer transition-aged youth to the county's TAY Programs.

1. SB-DBH operates the "One Stop" TAY Centers to improve access and engagement via integrated services to TAY youth who meet criteria for SB-DBH services and may be experiencing homelessness. An array of services and social support programs are provided through this center, based on strategic partnerships with organizations whose mission it is to serve this population through education, careers, lifestyle and wellness, and other supportive services. Peer and Family Advocates (PFA) are also part of the support offered to TAY. The staff at the Center can assist youth in finding linkages to any type of social supports: community, educational, social, faith-based, or cultural.

2. The Community Wholeness and Enrichment program provides prevention and early intervention services to transition-aged youth. The program also incorporates outreach and engagement strategies, including information dissemination, educational presentations, and trainings on the signs and symptoms related to behavioral health, and suicide prevention. These outreach and engagement activities are conducted at various community and faith-based organizations as well as at schools throughout the region.

3. SB-DBH also conducts access and engagement by helping improve educational and career pathways. Some examples include:

    a. TAY program services and events to outreach and engage unserved TAY and, when appropriate, their families in the behavioral health system so they can receive appropriate services. Services include but are not limited to: Health Fairs, Job Fairs, Street Outreach and weekly orientations.
    b. SB-DBH participates in a partnership with Inland Coalition for building career pathways.
    c. SB-DBH participates in a partnership with the Workforce Development Department's youth network programs.
    d. School-based providers are co-located on high school campuses to educate school personnel to identify youth with behavioral health needs and to refer them to services.
    e. Expansion of the *Promotores de Salud* program to include a youth *promotores* model.

QUESTION 1C:

Do you have any recommendations to improve outreach or services to specific ethnic or cultural groups of adolescents or transition-aged youth?

Yes X No____. If yes, please list briefly.

Culturally-based activities to build awareness and education about behavioral health conditions is a primary recommendation. SB-DBH culturally-specific subcommittees of the SB-DBH Cultural Competency Advisory Committee which help to shape and inform these services are recommended as a way to shape locally informed outreach and services. SB-DBH currently has 12 culturally-specific subcommittees:

1. Asian Pacific Islander Awareness Subcommittee
2. African American Awareness Subcommittee
3. Latino Awareness Subcommittee
4. Native American Awareness Subcommittee
5. LGBTQ Awareness Subcommittee
6. Co-Occurring Substance Abuse Awareness Subcommittee
7. Disabilities Awareness Subcommittee
8. Spirituality Awareness Subcommittee
9. Transitional Age Youth Awareness Subcommittee
10. Veterans Awareness Subcommittee
11. Women Awareness Subcommittee
12. Consumer and Family Members Awareness Subcommittee

The particularly effective strategies to improve outreach and services in our community are:

1. Providing behavioral health education at schools concentrated in geographic areas with high levels of diverse groups.

2. A LGBTQ Community Health Worker program targets outreach to the LGBTQ-population's needs through field-based outreach.

3. The Community Health Worker and *Promotores de Salud* programs have been effective in improving outreach and services due to being field- and community-based.

4. Staff and providers who reflect the culture and understanding of the target population are members of the subcommittees. This allows specific strategies to meet the unique needs of the populations and cultures.

5. Outreach efforts to Faith-based Organizations (FBO) are also recommended. The SB-DBH Spirituality Subcommittee works on an array of projects, which include resource development, trainings, policy advocacy, and other culture-specific activities that raise behavioral health and spirituality awareness, increase access to care and educate staff and

the community on how to integrate spirituality into behavioral health services. Ongoing efforts include identification and outreach to FBOs within San Bernardino County, with the goals of offering resources on behavioral health and wellness, providing education on department services, and building avenues for open communication. As FBOs are the first place many people go when experiencing a behavioral health condition, strong partnerships with FBOs will help outreach and services to many people, as well as address cultural needs. This connection and exchange of information creates more awareness, stronger families and communities, and results in more education to children and youth.

6. SB-DBH has a Department Diversity Committee (DDC) that is tasked with increasing diversity within the workforce. The DDC is committed to helping SB-DBH identify staff with cultural and linguistic backgrounds that meet the diverse needs of the constituents we serve.

7. Another strategy being considered is developing an ombudsman-type office to assist smaller or new community based organizations in navigating the county contracting process to help enhance the number and type of providers submitting applications during the request for proposal and qualifications processes.

QUESTION 1D:

What are your main strategies for assisting <u>parents/caregivers</u> of children with mental health needs? Please list or describe briefly.

SB-DBH has a range of strategies implemented through programs to address the needs of parents and caregivers of children with behavioral health needs. Programs throughout the children's system of care are strongly encouraged to provide support and assistance to parents and caregivers for the children and youth being treated for behavioral health issues. The nature of this support varies between programs and is provided in manners consistent with the needs for different ages of the children and youth being served. For example, when serving youth aged 0-5 the support provided often is encapsulated within the interactive therapy services. Parent Child Interactive Therapy (PCIT) is designed to address the child's behavioral health issues through supportive and directive efforts which enable the caregiver to address the child's needs more effectively.

For older youth, a caregiver may or may not be present in the direct services provided (e.g., family therapy); however, all programs are encouraged to provide collateral services. These EPSDT Medi-Cal funded services are designed to incorporate significant others into the treatment process without physically incorporating the caregiver into the therapy or rehabilitation sessions. Additionally, all children and youth in need of high level services provided through

FSP are served through a program which incorporates a Parent Partner within the service team. These Parent Partners work for a variety of Community Based Organizations (CBOs) contracted to implement the FSP and provide a centralized coordination through SB-DBH's Parent Partner Coordinator.

Specific SB-DBH programs for parents and caregivers:

1. The LIFT program provides services and support to low-income pregnant mothers throughout their pregnancies and continuing through their children's second birthday. Using the evidence-based Nurturing Parenting™ program, parents and caregivers are empowered with new knowledge and skills to help raise healthy children. Services are provided in the families' homes to help parents and caregivers receive the assistance they need in a comfortable and accessible environment.

2. A maternal behavioral health program in collaboration with 2-1-1 to help mother's with post-partum depression gain connectivity to support groups.

3. The National Curriculum and Training Institute® Crossroads Education© offers evidence-based Adult Parenting curriculum to help and support parents and caregivers as they learn how to better help their children in changing negative behaviors and motivating positive ones.

4. Family Resource Centers (FRC) work closely with parents and caregivers of children with behavioral health needs and use a variety of curricula to provide the knowledge and skills to thrive as a family. FRCs utilize the Strengthening Families Program, which helps improve parenting skills and family relationships. Also used are the National Curriculum and Training Institute® Adult Parenting curriculum and Nurturing Parenting™ program. Therapeutic treatment services, psychoeducation, and support groups also are available to parents and caregivers where they may receive support and education to help empower them and their families.

5. The Preschool PEI Program provides behavioral health education and support to parents of preschool-aged children to help prevent and reduce the occurrence of aggressive and oppositional behaviors. The program utilizes The Incredible Years® parenting training curriculum that focuses on strengthening parenting competencies and fostering parental involvement in children's school experiences. This, in turn, helps to promote academic, social, and emotional skills in children while reducing behavioral problems.

CFS has identified that postpartum depression is a major risk factor for children to be removed from a home. SB-DBH and CFS partner to identify parents early for potential postpartum depression. This involves bi-annual trainings for clinicians, social workers, psychiatrists, pediatricians to identify signs of post-partum depression in parents. Family Resource Centers (FRC) help identify and screen the cases and refer into appropriate levels of care and provide support/group therapy.

Access: Timely Follow-up Services after Child/Youth Psychiatric Hospitalization

The goals of timely follow-up services after psychiatric hospitalization are to promote sustained recovery and to prevent a relapse that could lead to another hospitalization. Children and youth vary greatly in their path to recovery. Sometimes a subsequent hospitalization is needed in spite of the best efforts of the healthcare providers, parents/caregivers, and the clients themselves.

"Step-down" is a term used by some mental health care professionals to describe a patient's treatment as "stepping down" from a higher level of care intensity to a lower level of care, such as outpatient care. Another example of step-down is when a hospital patient is transferred to crisis residential care or day treatment for further stabilization to promote a smoother transition to outpatient care.

Figure 4 on the next page shows data for the overall population of children and youth under the age of 21 who were discharged from a psychiatric hospitalization. In the upper half of the figure are data showing trends from one fiscal year to the next. The columns in this table show the overall percentages of clients with follow-up services within 7 days and those who received such services within 30 days. These time frames reflect important federal healthcare quality measures that are used, not only for mental health, but for medical discharges after hospital stays for physical illnesses and injuries.

The lower half of Figure 4 shows graphs of the median and mean (average) times for outpatient follow-up (stepdown) services following discharge from child/youth psychiatric hospitalization. These are two important measures that can be used to evaluate whether timely follow-up services are provided. But, because some clients do not return for outpatient services for a very long time (or refused, or moved), their data affects the overall average (mean) times in a misleading way due to the large values for those "outliers." Instead, the use of median values is a more reliable measure of how well the county is doing to provide follow-up services after a hospitalization.

A related concern includes how we help children and youth handle a crisis so that hospitalization can be avoided. Although we do not have data for mental health crises, similar follow-up care and strategies are likely to be employed. Your local board may have reviewed the range of crisis services needed and/or provided in your community

for children and youth. Many counties have identified their needs for such programs or facilities to provide crisis-related services.[14]

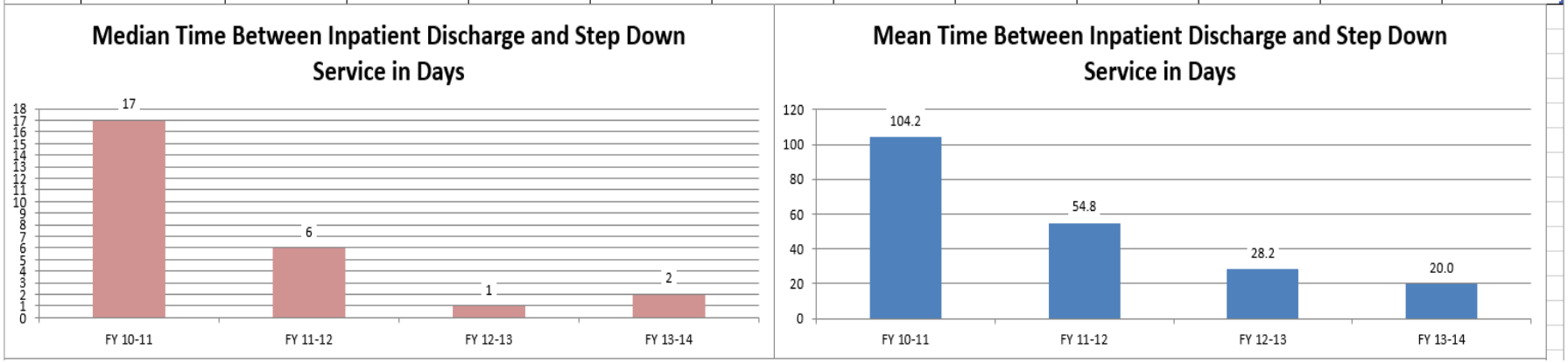
[14] Statewide needs for youth crisis services were reviewed in a major report by CBHDA (County Behavioral Health Directors Association) in collaboration with the MHSOAC. Your local advisory board/commission may find this report highly informative (released in late Spring, 2016).

Figure 4. Time to Follow-up Services after Child/Youth Discharge from Psychiatric Hospitalization. (2010-2014).

Your County: San Bernardino

San Bernardino County as of July 28, 2015

Service FY	Count of Inpatient Discharges with Step Down within 7 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 7 Days of Discharge	Count of Inpatient Discharges with Step Down within 30 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 30 Days of Discharge	Count of Inpatient Discharges with a Step Down > 30 Days from Discharge	Percentage of Inpatient Discharges with a Step Down > 30 Days from Discharge	Count of Inpatient Discharges with No Step Down**	Percentage of Inpatient Discharges with No Step Down	Minimum Number of Days between Discharge and Step Down	Maximum Number of Days between Discharge and Step Down	Mean Time to Next Contact Post Inpatient Discharge (Days)	Median Time to Next Contact Post Inpatient Discharge (Days)
FY 10-11	788	30.4%	1388	53.6%	810	31.3%	391	15.1%	0	1630	104.2	17
FY 11-12	1188	46.4%	1704	66.5%	540	21.1%	317	12.4%	0	1200	54.8	6
FY 12-13	1342	64.4%	1581	75.8%	265	12.7%	239	11.5%	0	897	28.2	1
FY 13-14	1410	56.7%	1809	72.8%	302	12.2%	374	15.1%	0	524	20.0	2



When examining the post-hospitalization data above, take special note of the percentages who received follow-up services within 7 days after discharge, within 30 days after discharge, or later than 30 days. These time frames reflect federal healthcare quality measures that are used, not only for mental health, but for medical discharges after hospital stays for physical illnesses and injuries. On lower left side graph, the median time for follow-up is the most useful measure of this outcome. Zero days would indicate that clients were seen as outpatients on the same day as the hospital discharge. Also take note of mean time (average) from discharge to step-down services (right side graph).

QUESTION 2A:

Do you think your county is doing an effective job providing timely follow-up services after a child or youth is discharged from a mental health hospitalization? Yes X No____.

If no, please describe your concerns or recommendations briefly.

While SB-DBH post-hospitalization follow-up care timeframes have significantly improved, it is important to note the concern about timely follow-up for foster children and youth from other counties who are hospitalized in San Bernardino County. As with many counties, the lack of psychiatric beds statewide increases the frequency of out-of-county hospitalizations, which can complicate follow-up. On-going partnership with hospitals is important to identify children and youth from other counties after the implementation of AB1299. There is also always a need for more providers to be a part of our network in County-operated, contractor, and fee-for-service settings. Most of the County has been designated as a mental health provider shortage area, and there is a nationwide shortage of child psychiatrists. Therefore, continued attention at statewide and nationwide levels on recruiting and retaining all levels of behavioral health providers is needed.

QUESTION 2B:

After a hospitalization or MH crisis, what are the main strategies used to engage and ensure prompt follow-up for outpatient care in transition-aged youth? Please list briefly.

The follow-up outpatient care strategies for TAY are:

1. SB-DBH has a TAY-specific co-located short term crisis residential program named The STAY, which is a comprehensive multidisciplinary program. It can serve as a step-down from psychiatric hospitalization and helps ensure appropriate follow-up care.

2. Frequently, our TAY do not "fit" in with the adult population as their needs and behaviors are manifested differently. This can lead to leaving treatment. Providing TAY-specific services and programs assists with strong follow-up care.

3. Once a TAY is identified in our outpatient system of care, a multi-disciplinary approach is used to engage and support TAY in their care. This involves case management and clinical care to meet the psychosocial, clinical, and support systems needs of the TAY population. Each TAY in the outpatient system of care has a psychiatrist, clinician, crisis

services staff, and a case manager available to them by appointment or on-call as necessary to meet their needs.

4. For youth involved in the juvenile justice system, any youth being detained at a Probation Juvenile Detention Facility who comes directly from an acute psychiatric facility are seen by the Forensic Adolescent Services Team (FAST) within 24 hours of being detained to ensure appropriate follow-up care is provided.

5. Finally, SB-DBH operates ACE (Assessment, Coordination & Engagement) at our general mental health clinics to facilitate post-hospitalization outpatient services. This program often offers same-day assessments and referrals to quickly engage TAY into follow-up care.

QUESTION 2C:

What are the main strategies used to help parents/caregivers of children access care promptly after a child's hospitalization or other mental health crisis? Please list briefly.

There are several strategies used to engage children after a hospitalization or crisis. As children are identified in the outpatient system of care a multi-disciplinary approach is used to engage and support both the child and their parents. This involves case management and clinical care to meet the psychosocial, clinical, and support systems needs of the child as well as referrals to the specialized children's system of care for Therapeutic Behavioral Services (TBS), School Aged Treatment Services (SATS), Intensive Home Based Services (IHBS), and other school based and non-school based specialized in-home care. Each child within the outpatient system of care has a child psychiatrist, clinician, crisis services staff and a case manager.

Timely follow-up after hospitalization: San Bernardino is doing such an effective job of providing timely follow up services after a psychiatric hospitalization because of the collaboration between multiple agencies and between units within SB-DBH. Establishing solid working relationships across units and agencies within such a large County requires proactive efforts and close monitoring. Through these efforts, Children and Youth Collaborative Services (CYCS) and the Medi-Cal Access Unit communicate daily regarding any 24 hour notices received from a psychiatric hospital. The extra efforts by the Access Unit allows the Parent Partner Coordinator an opportunity to review how best to serve a child recently hospitalized. As a member of CYCS, the Parent Partner links the family to the most appropriate resources (e.g, Children's Intensive Services – CIS) and is easily able to review any specific child with a Clinic Supervisor within CYCS. In some situations, the action taken is simply to make sure that the current service provider is aware of the hospitalization. In other situations, there are pre-designated programs which receive the referrals (e.g., Dependents who are hospitalized are

referred to a Comprehensive Children and Family Support Services (CCFSS FSP program). There are also complicated situations in which CYCS clinical staff need to become more involved to clarify the best course of action.

Strategic partnerships: The Community Based Organizations understand the importance of prioritizing children who have recently been hospitalized. Although each agency has a unique referral processing system, all of them prioritize these children and youth, which facilitates post-hospitalization follow-up and family support. Integrated New Families Opportunities (INFO) provides 24/7 case management services to assist the families/youth in crisis situations. Staff who are familiar with the family are available after hours and on weekends to address any issues that arise with the youth and are able to intervene immediately as needed. A Peer and Family Advocate is available to work with the youth, parents, and family providing resources and referrals to other need services.

QUESTION 2D:

The follow-up data shown above are based on services billed to Medi-Cal. As a result, those data do not capture follow-up services supported by other funding sources. Examples may include post-hospitalization transportation back to the county, contact with a Peer/Family Advocate, or MHSA-based services.

Please list some <u>non</u>-Medi-Cal funded strategies your county may use to support families/caregivers following a child's hospitalization or other MH crisis.

The efforts of Children and Youth Collaborative Services (CYCS) to ensure that children and youth who have recently been hospitalized are linked to good services are all done without any Medi-Cal funded services. The Parent Partner element is funded through our MHSA resources. The clinical consultations and activities by other CYCS staff are funded through a combination of Realignment, EPSDT Medi-Cal, and MHSA resources. The Family Resource Centers offer support groups for children, youth and families that are experiencing challenges related to behavioral health conditions and are funded through MHSA prevention and early intervention funds. Recovery Based Engagement and Support Teams (RBEST) provides ongoing family support and education for family members of consumers age 18 and over who are not engaged in appropriate behavioral health services. This is funded through MHSA Innovation. Community Crisis Response Team (CCRT) responds to all behavioral health crisis calls, including those related to children and youth and their families. CCRT is largely funded through MHSA.

VULNERABLE GROUPS WITH SPECIALIZED MENTAL HEALTH NEEDS

Foster Children and Youth

Foster children and youth comprise a vulnerable group that faces considerable life challenges. Mental health consequences may result from the traumatic experiences which led to their placement in foster care. Foster children and youth are just 1.3 % of all Medi-Cal eligible children and youth (ages 0-20). However, they represent 13 % of the total children and youth who received Specialty Mental Health Services (SMHS) in one year (FY 2013 – 2014). SMHS are services provided to children and youth with serious emotional disorders (SED) or to adults with serious mental illness (SMI). These mental health challenges affect outcomes in all aspects of their lives as has been described in recent studies[15,16] of foster youth in California schools:

The key findings for California foster youth included:

- **Time in Foster Care –** More than 43,000 (or about one of every 150 K-12) public-school students in California spent some period of time in child welfare supervised foster care.
- **Reason for Removal –** Of students in foster care, 78% were removed from birth families due to neglect, 11% physical abuse; 4% sexual abuse; and 7% other reasons.
- **Grade Levels –** Of these students in foster care, 40% were in Elementary School; 23% were in Middle School; and 36% were in High School.
- **An At-risk Subgroup –** Nearly one in five students in foster care had a disability compared to 7% of all K-12 students and 8% low socioeconomic status (SES) students.
- **School Mobility –** Among students who had been in foster care for less than one year, 48% had changed schools during the academic year.
- **Achievement Gap –** Proficiency in English language arts for students in foster care was negatively correlated with grade level.
- **Drop-out and Graduation –** Students with three or more placements were more than twice as likely to drop out as students with one placement, although this single-year dropout rate is still twice as high as that for low SES students and for K-12 students.

Conclusion: Students in foster care constitute an at-risk subgroup that is distinct from low socioeconomic status students regardless of the characteristics of their foster care experience.

[15]The Invisible Achievement Gap, Part 1. Education Outcomes of Students in Foster Care in California's Public Schools. http://stuartfoundation.org/wp-content/uploads/2016/04/the-invisible-achievement-gap-report.pdf. Also see: Child Welfare Council Report, 2014-2015 for more source material, at: http://www.chhs.ca.gov/Child%20Welfare/CWC%202105%20Report-Approved090215.pdf.

[16] The Invisible Achievement Gap, Part 2. How the Foster Care Experiences of California Public School Students Are Associated with Their Education Outcomes. http://stuartfoundation.org/wp-content/uploads/2016/04/IAGpart2.pdf

As they reach adulthood, most foster youth will need continuity of care through Medi-Cal for services to promote mental health, independence, and connections within the community, including housing supports to avoid homelessness. Homelessness is a common outcome for foster youth who leave the system without either re-unification to their family of origin or an attachment to a permanent family.

One subgroup of foster youth has been referred to as "Katie A Subclass members," due to a lawsuit filed in federal court regarding their need for certain types of more intensive mental health services. The services included under the 2011 court settlement order are intensive home-based services, intensive care coordination, and therapeutic foster care. More recently, DHCS recognized that other children and youth also have a right to receive such services if there is a medical necessity.

The complex needs and large numbers statewide present challenges to the foster care and mental health systems. The numbers of foster youth who are receiving Specialty Mental Health Services are shown below. These data do not include those with mild to moderate mental health needs who are served in the Medi-Cal Managed Care System. Also, these data do not reflect those with disabilities who are served through school-based mental health services as part of an "Individual Educational Plan."

HOW MANY FOSTER CHILDREN AND YOUTH RECEIVE SPECIALTY MENTAL HEALTH SERVICES,* INCLUDING "KATIE A" SERVICES?

Statewide: (FY 2013-2014) Certified Medi-Cal eligible Foster Care Youth (age 0-20): **77,405.**

- Total Number of Medi-Cal Foster Youth who received at least one Specialty MH Service: **34,353** (service penetration rate is 44.3 %).
- Total Medi-Cal Eligible Foster Care Youth who received five or more Specialty MH Services: **26,692**.

Statewide: (FY 2014-2015) Total Unique Katie A. Subclass Members: **14,927**

- Members who received In-Home Behavioral Services: **7,466**
- Those who received Intensive Case Coordination: **9,667**
- Those who received Case Management/Brokerage: **9,077**
- Received Crisis Intervention Services: **523**
- Received Medication Support Services: **3,293**
- Received Mental Health Services: **12,435**
- Received Day Rehabilitation: **285**
- Received Day Treatment Intensive service: **63**
- Received Hospital Inpatient treatment: **19**
- Received Psychiatric Health Facility treatment: **41**
- Therapeutic Foster Care: Data not yet available.

* Data reports are from: http://www.dhcs.ca.gov/Pages/SMHS-Reports-2016.aspx. The data are for fiscal years 2014 or 2015 (depending on which data are the most recent available at the time of this report).

Next, the figure below shows the percentage of foster children under 18 who received specialty mental health services. Note the trends year-to-year for your county and the comparisons to counties with populations of similar size and to the state.

There may be several explanations possible for any observed differences. For example, some counties find it necessary to place a significant number of foster youth out-of-county in order to find specialized services or the most appropriate and safe living situation.

Another explanation is that the recent expansion of Medi-Cal markedly increased the total numbers eligible for coverage. More children and youth are now eligible to receive specialty mental health services. Even if there was an increase in total numbers who received these services, there may have been a decreased percentage of total eligible persons served. Also, in some counties there are shortages of mental health professionals trained to work with children and youth or who also have bilingual skills.

Figure 5. Percentages of Foster Youth Who Received Specialty MH Services

Your County: San Bernardino

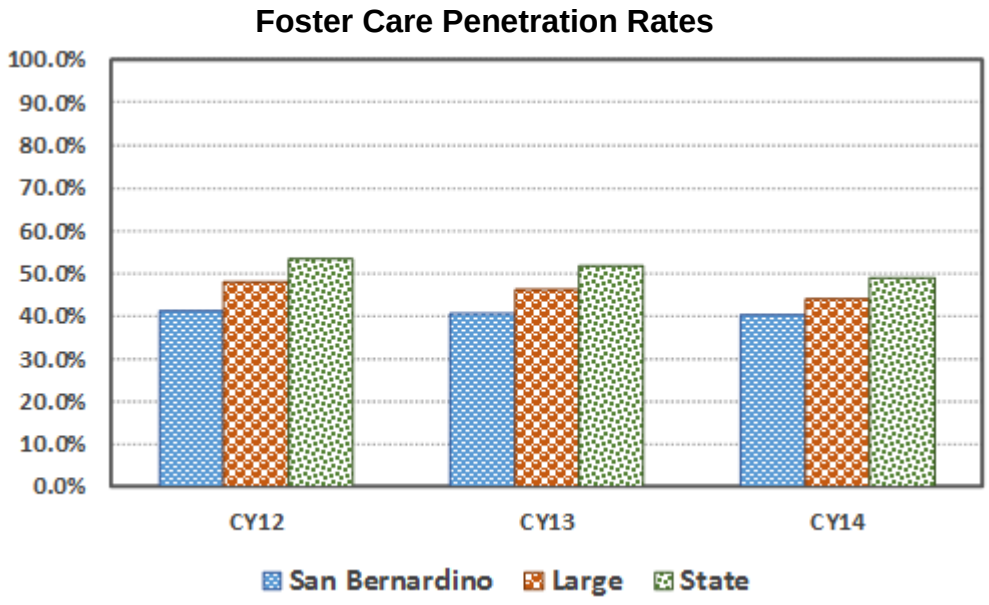


Figure 5. Shown above are data for the percentage of foster care youth who received specialty mental health services, during three calendar years (CY): 2012, 2013, and 2014. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows the average for all counties with populations of similar size to yours. The third bar (green) shows the state average values.

[17] Behavioral Health Concepts, Inc. California EQRO for Medi-Cal Specialty Mental Health Services. EQRO is the External Quality Review Organization. www.CALEQRO.com, see "Reports," and select your county to view.

QUESTION 3A:

What major strategies are used in your county to provide mental health services as a priority for foster youth?

Please list or describe briefly.

Strategies utilized by SB-DBH to provide mental health services to Dependents generally fall into two categories: (1) efforts to identify and link children and youth to services and (2) efforts to ensure children and youth continue to receive appropriate care.

Regarding efforts to identify and link children and youth to services, the Child and Youth Connections program under Mental Health Service Act Prevention and Early Intervention (PEI) has implemented Healthy Homes and Screening, Assessment, Referral, and Treatment (SART). Both programs have been operational under their current structure for approximately 10 years. Healthy Homes is overseen by a centralized Clinic Supervisor of CYCS and comprised of SB-DBH clinicians who are co-located at a regional CFS office. SART is a program jointly funded with First 5 of San Bernardino and operationalized by four Community Based Organizations (CBOs) at six locations throughout the county.

CFS has a policy that all children and youth with a new child welfare case will be referred to one of these Child and Youth Connections programs to conduct a screening for behavioral health needs and either conduct, or facilitate an assessment for these services. Dependents aged 0-5 are referred to SART and all others are referred to Healthy Homes. Efforts made to facilitate this process includes creating a streamlined referral mechanism, the establishment of a judicial standing order to allow CFS staff to authorize mental health treatment, and a specialized network within the SB-DBH Children's System of Care to prioritize these referrals. In addition to these structural and procedural efforts, regular meetings are conducted in the regional CFS offices to troubleshoot any issues.

Regarding efforts to ensure Dependents are provided appropriate care, there are multiple efforts to monitor services for children who are potential Katie A sub-class members or have already been identified as sub-class members. Close collaboration between CFS, CFS's data agency (Human Services – Research Outcomes & Quality Support: HS-ROQS), SB-DBH's Research and Evaluation (R&E), and CYCS has resulted in monthly data reviews for Dependents.

The reviews focus on (1) Dependents identified by HS-ROQS as meeting some of the criteria for Katie A sub-class membership (aka, "Potentials") and (2) monitoring services provided to Dependents identified as meeting Katie A sub-class membership criteria (aka, "Actuals"). For children identified as "potentials," CYCS staff review the services currently being provided and facilitate changes in services if needed. For children identified as "actuals," CYCS staff review services patterns for consistency and prompt service providers to make changes as deemed appropriate after consultation.

The San Bernardino One Stop TAY programs were developed in part to address the emerging needs of youth aging out of the Child Welfare system. The One Stop TAY Center is modeled as a drop-in center and not as a mental health clinic only in order to improve TAY participation and allow TAY to (1) selectively utilize those services needed to maximize their individual potentials (Recovery, Wellness, and Resiliency Model) while already in the community, and (2) to prepare them for entry into the community. The One Stop TAY Center in partnership with the Departments of Probation, Children and Family Services, and numerous community partners assist TAY in achieving their goals of becoming independent, staying out of the hospital or higher levels of care, thereby reducing involvement in the criminal justice system and reducing homelessness.

Dependents who are detained at Juvenile Detention and Assessment Center (JDAC) are referred to the court to determine if the youth would be better assisted by CFS, Probation, or if they should be dually supervised, known as "Dual Jurisdiction." A Mental Health Professional from the Juvenile Justice Program participates in the weekly MDT prior to court and will share any pertinent mental health information on detained youth to assist both departments in determining how to best serve the youth.

QUESTION 3B:

Do you think that your county does a good job of coordinating with your county department of social services or child welfare to meet the MH needs of foster care children and youth?

Yes X No____. If no, please explain briefly.

SB-DBH, Children and Family Services (CFS), and Probation work closely together to design and implement programs that will meet the needs of Dependents and Wards. The close collaboration has resulted in several programs that are jointly funded and monitored.

QUESTION 3C:

Do you have any comments or suggestions about strategies used to engage foster youth and provide mental health services?

Yes X No____. If yes, please list or describe briefly.

There are multiple pragmatic obstacles to starting services with foster youth that may be effectively addressed through structural, informational, and judicial efforts. None of these address the unique cultural needs experienced by foster youth, but help create a system in which the individual needs may be met more effectively. One barrier is capacity due to the lack of

hospital beds, provider shortages, and other foundational services that need to be met before expanded programming is possible. Changes to the law for medication support services will affect psychiatrists who are part of the fee-for-service network and their willingness to comply with the new JV-220 paperwork requirements that becomes effective July 1, 2017. Many psychiatrists have indicated they will be unwilling to treat foster youth as a result.

The following strategies have been helpful in working with foster youth:

1. *Co-located staff:*

    a. The co-located staff at the Children and Family Services (CFS) offices allows for CFS staff to have much easier access to SB-DBH staff. This structural change has pros and cons in regards to efficiency. Given the size of SB-DBH, staff can be stationed 45 minutes away from each other. This makes them isolated from other SB-DBH colleagues, and additional efforts are needed to create a consistent message and response from the clinicians. However, having them included in CFS offices does more to promote collaboration than any other outreach efforts.

    b. The County-operated TAY center has a co-located Children and Family Service Social Worker II integrated with the TAY Multi-disciplinary Treatment team. All San Bernardino TAY programs attend and participate in regularly scheduled community partnership meetings, special events, and county wide collaborative taskforce activities that serve Dependents.

2. *Outreach and Education*: Informational strategies focus on trying to help staff from each agency understand the focus and limitations of each other's positions. For SB-DBH, this includes maintaining a resource referral workbook specifically designed for CFS case workers. Another example is creating concise communications about limits of confidentiality to encourage appropriate disclosures by mental health staff and provide a clear statement of limitations that are imposed so that CFS staff do not perceive refusals to communicate as a personal decision.

3. *Judicial orders for treatment:* The biggest impact upon serving Dependents has been the creation of a standing judicial order which authorizes CFS to consent to mental health treatments and authorizes behavioral health staff to release information. Prior to this standing order, extensive efforts were needed to obtain authorizations from biological parents and/or individualized court orders to conduct an assessment. This one standing order has allowed CFS to refer a child for services and provide the behavioral health staff with all needed documentation to start services.

Lesbian, Gay, Bisexual, Transgender and Questioning Youth (LGBTQ)

LGBTQ youth are another group which may be underserved or inappropriately served. Most counties say that LGBTQ youth are welcome to engage in their standard programs and receive services, as are all other cultural groups. However, it is essential to understand how counties are serving the specific needs and difficulties faced by LGBTQ youth. Members of the LGBTQ community access mental health services at a higher rate than heterosexuals, with some reports suggesting that 25-80 % of gay men and women seek counseling. Many individuals report unsatisfactory experiences due to a therapist's prejudice, inadvertent bias, or simple inability to comprehend the experiences and needs of their LGBTQ clients.[18]

Research and experience demonstrate that LGBTQ youth have unique needs that are most effectively provided by therapists and program directors with special training in addressing these unique populations. Outcomes are better when therapists and program leaders have received this specialized training.

Particular risks for LGBTQ youth and children include discrimination, bullying, violence, and even homelessness due to rejection by their families of origin or subsequent foster homes. Homelessness introduces great risk from all the hazards of "life on the street." In contrast, family acceptance of youth is crucial to their health and wellbeing.[19]

The Family Acceptance Project:
A promising area of research and practice is represented by the Family Acceptance Project headed by Dr. Caitlin Ryan in San Francisco, CA. She and her team developed the first family-based model of wellness, prevention, and care to engage families to learn to support the LGBTQ children across systems of care. Her research on the protective factors for LGBTQ youth has been published in peer-reviewed journals. These studies found that parental and caregiver behaviors can help protect LGBTQ youth from depression, suicidal thoughts, suicide attempts, and substance abuse.

In contrast, she found that *the LGBTQ youth who were rejected by their families were eight times as likely to attempt suicide, nearly six times more likely to have high levels of depression, and three times as likely to use illegal drugs*.

The Family Acceptance Project has assisted socially and religiously conservative families to shift the discourse on homosexuality and gender identity from morality to the health and well-being of their loved ones, even when they believe that being gay or transgender is wrong. This effort included development of multicultural, multilingual, and faith-based family education materials designed to prevent family rejection and increase family support.

"We now know that kids have their first crush at about age 10. Many young people today are now coming out between ages 7-13. Parents sometimes begin to send rejecting messages as early as age 3…. These early family experiences … are crucial in shaping [their] identity and mental health."

[18] P. Walker et al., "Do No Harm: Mental Health Services: The Good, the Bad, and the Harmful."

[19] Dr. Caitlin Ryan, 2009. Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. *Also see*: Ryan, C. (2014). Generating a Revolution in Prevention, Wellness & Care for LGBT Children & Youth, Temple Political & Civil Rights Law Review, 23(2): 331-344.

QUESTION 4A:

Does your county have programs which are designed and directed specifically to LGBTQ youth? X Yes ___ No.

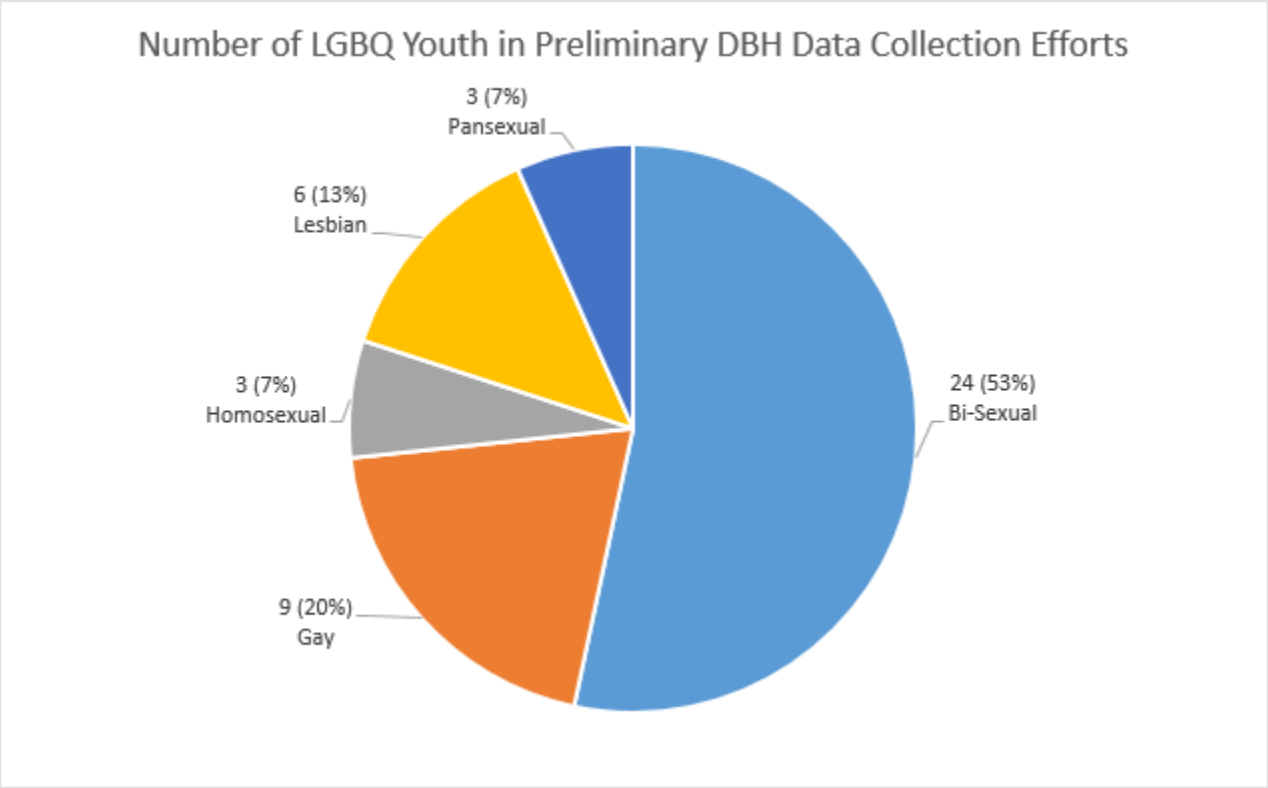
If yes, please list and describe briefly.

SB-DBH operates programs specifically designed to meet the needs of LGBTQ youth. SB-DBH has the LGBTQ Community Health Worker Program, which is funded by the Mental Health Services Act, under the Prevention and Early Intervention component. This program is contracted out to Rainbow Pride Youth Alliance, a community based organization. The mission of Rainbow Pride Youth Alliance is "to provide a safe, healthy, and enriching environment for gay, lesbian, bisexual, transgender, queer, questioning, and intersex (LGBTQI) youth of the Inland Empire." The LGBTQ CHW programs are specifically designed to support the LGBTQ population. The purpose of the CHW program is to engage, encourage, educate, train, and learn from potential responders about ways to respond effectively to early signs of potentially severe and persistent mental illness. The definition of "potential responders" includes individuals who are in a position to identify early signs of potentially severe and persistent mental illness, who can provide support, and/or who can refer individuals who need treatment or other behavioral health services to appropriate care. The CHW program utilizes members of the community to provide basic mental health education and outreach to the LGBTQ community using curricula specifically designed for this population. Services are aimed at increasing the recognition of the early signs of mental illness as well as increasing the use of services without fear of discrimination or stigmatization.

The One Stop TAY and STAY programs have LGBTQ-specific groups and services to provide support to LGBTQ TAY. This often includes educating other youth on how to better support their LGBTQ peers. The TAY programs provide structured group settings on the importance of improving child welfare practice with LGBTQ youth, including the impact and scope of LGBTQ youth in all systems of care that we serve. Our goal is to help participants to assess their own values and beliefs to identify strategies for balancing personal views with professional responsibilities. We also strive to increase competency in using accurate and culturally appropriate terminology with this population of youth.

Some additional programs that support LGBTQ youth are:

1. Some student assistance programs provide LGBTQ support groups.
2. Family resource centers have identified safe zones for LGBTQ services for youth and adults, especially important in the high desert area of the county.
3. Accurately and sensitively collecting statistics on LGBTQ youth remains a challenge. However, below is information about the number of LGBQ youth served in some specialty programs that have initiated sexual orientation data collection (primarily for STAY & TAY programs):



QUESTION 4B

Does your county or community have programs or services designed to improve family acceptance of their LGBTQ youth and/or with the goal of helping to heal the relationship of the youth to his/her family? Yes X No____.

If yes, please list or describe briefly.

The following programs aid in the education of families and the community at large on LGBTQ youth and unique challenges they may face:

The SB-DBH Office of Cultural Competence and Ethnic Services (OCCES) has twelve culturally specific subcommittees which work towards providing community education, and increasing advocacy efforts and policy development in regards to mental health and wellness related issues. One of the twelve subcommittees is the LGBTQ subcommittee. The LGBTQ subcommittee has provided six trainings on various issues affecting the LGBTQ community during 2016, resulting in training over 670 community members, department staff, other county staff and contract providers. Education is provided to the families of LGBTQ youth on issues specific to the population such as bullying, risk of suicide, and rates of behavioral health conditions.

The OCCES trains other county departments, such as Department of Aging and Adult Services, Department of Children and Family Services, Public Health, Probation, District Attorney, and community organizations such as Inland Regional Center and various domestic violence organizations on effective cultural approaches when engaging with LGBTQ youth. Many of these entities also work with family members, so the education and awareness of these staff can help improve the education and awareness of families as well. OCCES trains local hospital staff, department staff and various organizations on appropriate ways to comply with AB959, and collect information on sexual orientation and gender identity in a culturally sensitive manner.

QUESTION 4C:

Do you have any comments or suggestions about services or how to address unmet needs for LGBTQ youth in your community?

Yes X No____. If yes, please list or describe briefly.

There are strategies SB-DBH would suggest for consideration in addressing unmet needs:

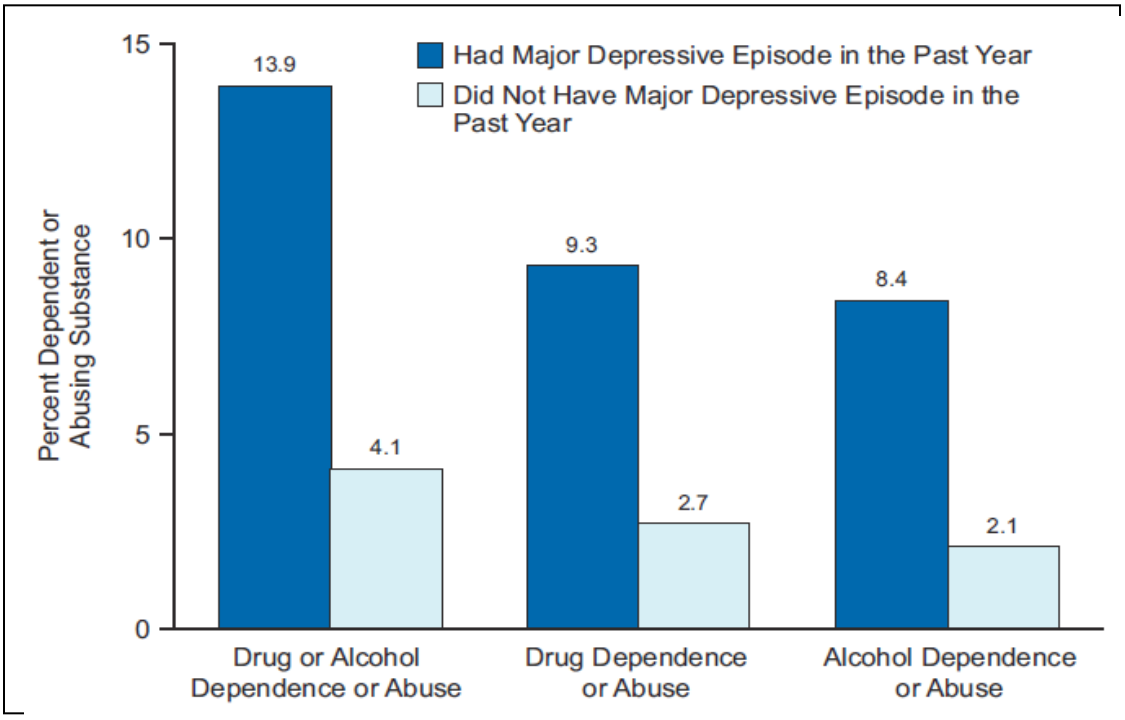
1. Increase education to local schools on LGBTQ issues.
2. Train more local community organizations to be safe spaces for LGBTQ youth.
3. Revise our business processes to ensure culturally sensitive compliance with legislation and regulations regarding the collection of LGBTQ-specific data.
4. Continue to provide ample opportunities for staff to receive culturally competent training on LGBTQ youth.
5. Continue our partnership with community based organizations to address unmet needs.
6. Develop a local resource guide highlighting services specifically to the LGBTQ community.

Children and Youth Affected by Substance Use Disorders

Counties generally have several levels of substance use disorder programs. These include prevention, treatment, and recovery supports. Prevention refers to services that target people before a diagnosable substance use disorder occurs, and may be based in schools or the community. Treatment refers to directly intervening in a substance use disorder using clinical means and evidence-based practices by trained clinical staff. Recovery support refers to supporting long term recovery and includes secondary prevention services as well. Resources for each of these main program areas are not equally available in all counties or areas of the state. Many small-population counties have very limited types of substance use treatment programs.

Young people who engage in early substance abuse may do so because they are experiencing mental health challenges. Children and youth who experience a major depressive episode are three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who do not have depression.[20] (See next figure, 2013 data, NSDUH).

Figure 6. Past Year Substance Abuse and Depression in U.S. Youth, Age 12-17.



[20] Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, at: http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf

Last year's Data Notebook (2015) included a section on substance use disorders in all groups but emphasized adults and those with co-occurring mental health disorders. Both community and school-based prevention efforts were also discussed.

Substance abuse services for children and youth were not specifically addressed last year. Therefore, our focus for this discussion is limited to treatment needs and services for children and youth. Both experience and evidence show that children and youth under age 18 are best served by substance use treatment programs which are designed specifically for their emotional and social developmental stages.

In California, many of the 30 smaller population counties (<200,000), have limited treatment options, with an emphasis on outpatient treatment or abstinence programs.[21] There is a shortage of providers and of narcotic treatment programs (NTP), which is of concern given recent trends in narcotic drug abuse in all age groups, including youth. It is unknown how many counties have substance abuse treatment programs (and what type) that are designed specifically for youth under 18 or even for TAY (ages 16-25).

For your review, we are presenting data for total numbers of youth who initiated substance use treatment during FY 2013-2014 by participating in one of these three types of treatment: **outpatient, "detox", or residential treatment programs**. (NTP services and pregnant mother programs are not included). During that year, individuals may have started treatment one or more times in either the same or another program. However, these data count only the first episode of substance use treatment for an individual within that fiscal year. Both statewide data and county data (where available) are shown.

[21]California Substance Use Disorder Block Grant & Statewide Needs Assessment and Planning Report, 2015. Presented as a collaborative effort between numerous staff at DHCS, CDPH, and the UCLA Integrated Substance Abuse Program. http://www.dhcs.ca.gov/provgovpart/Documents/2015-Statewide-Needs-Assessment-Report.pdf

San Bernardino County:

Alcohol/Drug Use in Past Month (Student Reported), by Grade Level: 2011-2013		
Grade Level	**Any**	**None**
7th Grade	N/R	N/R
9th Grade	N/R	N/R
11th Grade	N/R	N/R
Non-Traditional	N/R	N/R
All	N/R	N/R

N/R = too little data was collected for valid reporting, or the survey data were not submitted to the agencies or contracted entities who perform the analysis (CA Department of Education, CA Healthy Kids Survey, or WestED, etc).

Numbers of Youth that Began Substance Use Disorder Treatment, FY 2013-2014:

California: Statewide

Age < 18: 14,957 Age 18-25: 23,614

Your County: San Bernardino

Age <18: 290 Age 18-25: 1,371

QUESTION 5A:

Does your county provide for substance use disorder treatment services to children or youth? Yes X No____

If yes, please list or describe briefly.

If no, what is the alternative in your county?

SB-DBH ADS provides substance use disorder (SUD) treatment for youth age 12 through 17 and adults 18 and over with the following services. The services are detailed with numbers of outpatient episodes. Episodes are used rather than counts of unique clients due to the frequency of multiple episodes per person. Therefore, episode count is a more accurate representation of volume and capacity.

1. *Outpatient Treatment – American Society of Addiction Medicine Level 1:* Organized service delivered in which treatment staff provides professionally directed evaluation and

treatment of substance use disorders. Counseling services are provided up to 9 hours per week for adults and less than 6 hours per week for youth.

Outpatient Treatment Episodes	Aged 12-17	Aged 18-25
FY 13-14	385	633
FY 14-15	334	677
FY 15-16	239	708

2. *Intensive Outpatient Treatment (IOT) - ASAM Level 2.1:* Organized service delivered by addiction professionals or addiction credentialed clinicians, which provides a planned regiment of treatment, consisting of regularly scheduled sessions within a structured program, for a minimum of 9 hours of treatment per week with a maximum of 19 hours per week for adults provided at minimum 3 hours per day, 3 days per week, and a minimum of 6 hours with a maximum of 19 hours per week for youth. This will be a new treatment option for SB-DBH ADS beginning on July 1, 2017.

3. *Perinatal Treatment Program - (ASAM Level 2.1):* The term "Perinatal" means treatment services designed for pregnant women and women with dependent children pursuant to Title 45 Code of Federal Regulations (CFR) Part 96, Section 96.124(c). The Department of Health Care Services (DHCS) Office of Women's and Perinatal Services (OWPS) oversees a statewide network of public-funded perinatal substance use disorder treatment programs that serve over 25,000 pregnant and parenting women and their children annually. In addition to these functions, OWPS staff supports activities in research, technical assistance, collaboration, coordination, education, and outreach for women's services throughout the State. The Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant (BG) requires States to expend a specified amount of funds for perinatal services to pregnant women and women with dependent children each state fiscal year (SFY). Perinatal Services Network Guidelines (PSNG) are developed by DHCS and outlines the SABG perinatal service requirements. The PSNG also includes core competencies for programs serving perinatal women. These core competencies are included in an effort to promote integrated programming approaches based on theories that fit the psychological, social, and developmental needs of women. The core competencies are not required services but rather standards of care guidelines for women's services. The objective of the Department of Behavioral Health's Perinatal Services is to provide or arrange substance use disorder treatment services and other therapeutic interventions to pregnant and substance misusing and/or parenting and substance misusing women, with children 10 years of age and younger which provides a planned regimen of treatment, consisting of regularly scheduled sessions within a

structured program, for a minimum of 9 hours of treatment per week for adults provided at minimum 3 hours per day, 3 days per week.

Perinatal Treatment Episodes	Aged 12-17	Aged 18-25
FY 13-14	3	182
FY 14-15	0	176
FY 15-16	0	155

4. *Residential Treatment - ASAM Level 3.1, 3.3 or 3.5:* In the Residential Treatment environment, an individual may require treatment that is slower paced, concrete and repetitive in nature. The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build positive behavioral patterns within a community. These services are provided to clients in a program which is maintained and operated to provide twenty-four (24) hour Substance Use Disorder Residential Treatment and Withdrawal Management services. Withdrawal Management is available for youth aged 13 through 17 and adults 18 and over.

Residential Treatment Episodes	Aged 12-17	Aged 18-25
FY 13-14	0	493
FY 14-15	0	528
FY 15-16	28	445

5. *Adult and Juvenile Drug Court Treatment Programs Drug Court Program Services* provide a highly structured and strictly monitored treatment alternative to prosecution for adults (18 years and older) arrested for non-violent, felony drug violations and who are admitted to the program by the Drug Court Judge based on a recommendation from the District Attorney, Legal Counsel, Probation and the Treatment Provider. Drug Court utilizes a team approach and the team consists of a Judge, the District Attorney, Legal Counsel, Probation, Treatment Court Coordinator, the Treatment Provider and the client. The client is focused on attempting to resolve his/her substance use related problems. The Treatment Provider works with the Drug Court Team to determine the client's treatment plan and to ensure the clients compliance with program. Weekly progress reports are made by the treatment Provider to the Drug Court Judge on the client's progress or lack of progress in the program. The client is required to make frequent court appearances at which time the Drug Court Team evaluates the client's progress and makes a determination on the client's status in the program; whether the client continues, is

sanctioned or terminated from the program and prosecuted on the original violation. The treatment program utilizes evidence-based curriculum that is provided in phases and incorporates the Drug Court 10 Key Components into the program such as:

1. Drug Testing (Key Component #5)
2. Judicial Supervision (Key Component #7)
3. Case Management (Key Component #8)
4. Educational/Vocational Services (Key Component #10)

Each phase the client enters involves a different aspect of their recovery such as individual and group counseling which may include gender specific groups. They cover topics such as relapse prevention, reasoning and anger management. All phases of treatment require random and observed drug testing and participation in self-help groups. The client must meet all program requirements to advance to each subsequent phase of the program and eventually graduate from the program with a reduced or dismissed charge on the original violation.

Drug Court Treatment Episodes	Juvenile Drug Courts Aged 12-17	Adult Drug Courts Aged 18-25
FY 13-14	44	172
FY 14-15	99	191
FY 15-16	88	178

6. *Community-Based Recovery Services Centers (CRSC)*: A community-based service center whose primary purpose is to support the recovery efforts from substance use disorders of persons in the community. Recovery Centers do not provide treatment and other clinical services, though it may be co-located with a certified clinic that offers these services. It provides a supportive substance free environment where persons in recovery and those seeking recovery can work together to secure resources that will help them sustain and strengthen their recovery efforts. Accordingly, the CRSC offers, both onsite and by referral, a myriad of services that includes a wide variety of focused self-help groups, healthy socialization opportunities, information dissemination, vocational and educational opportunities, training classes, and the like. It also provides and gives access to services for the families and significant others of persons in recovery and can serve as a focal point for primary prevention services. All services are provided free of cost to attendees.

Community-Based Recovery Service Centers offer the following services, at minimum:

1. Smoking Reduction/Cessation
2. Training - Drug Education
3. Training - Life Skills
4. Groups - Family Support
5. Social Activities
6. Self-Help Meetings: Alcoholics Anonymous (AA), Narcotics Anonymous (NA), AL-Anon, Eating Disorders Anonymous, Dual Diagnosis Anonymous, and Overeaters Anonymous (OA), Cocaine Anonymous, and Women's Narcotics Anonymous.
7. Parenting Education

If the Medicaid expansion is repealed, SUD treatment services would significantly be affected, as approximately 70% of Medi-Cal beneficiaries served by SB-DBH ADS are eligible for Medi-Cal through the expansion. Traditionally, SB-DBH ADS has served all age groups, and if individuals did not have Medi-Cal and had no insurance, they could receive services and utilize other funding sources they may be eligible for, such as Children and Family Services (CFS), CalWORKs, AB109, and Block Grants. The ability to leverage Medi-Cal allows the Block Grant and other funds to be spread out to serve more individuals. The repeal of Medicaid expansion would significantly reduce funding streams, meaning less funds would be available to serve all age groups.

QUESTION 5B:

Do you think your county is effective in providing substance use disorder treatment to individuals under the age of 18? Yes X No___.

Please explain briefly.

SB-DBH ADS has a continuum of care for youth that utilizes the American Society of Addiction Medicine (ASAM) Criteria for placement into the most appropriate level of care. The youth is assessed utilizing a biopsychosocial assessment and the Teen Addiction Severity Index (T-ASI). It yields ratings in seven domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status, and psychiatric status. ASAM Criteria are then utilized to determine the appropriate level of care to best meet the needs of the youth, such as Residential Treatment or Outpatient Treatment. Youth can be stepped up or down in their treatment level of care to meet their specific needs, as necessary. Youth require unique approaches to treatment for SUD services and SB-DBH ADS utilizes evidence based psychosocial treatment, such as cognitive behavioral therapy and motivational interviewing along with evidence base curriculums, such as the Teen Matrix Model, National Curriculum

Training Institute (NCTI) Cognitive Life Skills, and Mindfulness Based Substance Use Treatment for Adolescents. Treatment consists of components such as individual and group counseling and family therapy and discharge planning services. Family therapy is designed to enhance insight into family interactions, facilitate emotional support and develop alternative strategies to address issues, problems and needs. Case management services are also provided to assist with any collateral needs the youth may have, such as medical, social, educational needs or other services that will support the overall health of the youth.

As depicted in the table below of the SUD Treatment Outcomes in FY 15/16, changes can be noted to behaviors that will improve the health and wellness of the clients who sought out and participated in treatment, they may relapse but the seeds of recovery have been planted.

SUD Treatment Outcomes FY 15/16

Modality	**Age**	**Outcome Examples**	**Number Or Percentage**	**Examples of Client or Community Impact**
Drug Court	12 - 17	From opening treatment episode to closing treatment episode the reduction in days spent in jail	93%	Reduced incarceration cost
	18 - 25	From opening treatment episode to closing treatment episode increase in clients paid days working	84%	Clients becoming more self-sufficient
Narcotic Treatment Program (NTP)	18 - 25	From opening treatment episode to closing treatment episode the reduction in client IV drug use	68%	Reduction in the risk of disease transmission
Outpatient Treatment	12 - 17	From opening treatment episode to closing treatment episode the reduction in clients physical health problem days	66%	Reduction in absences from school
	18 - 25	From opening treatment episode to closing treatment episode the increase in clients enrolled in job training	63%	Clients becoming more self-sufficient
Perinatal Treatment	18 - 25	From opening treatment episode to closing treatment episode the reduction in client IV drug use	100%	Babies are born drug free, reduced medical costs
Residential Treatment	12 - 17	From opening treatment episode to closing treatment episode the reduction in family conflict days	100%	Reduction in family stressors which can propel youth to substance mis-use and relapse
	18 - 25	From opening treatment episode to closing treatment episode the reduction in client days living with a substance user	91%	Change in healthy living habits

Justice System-Involved Youth with Behavioral Health Needs

Children and youth with significant emotional or mental health issues may engage in behaviors which bring them into contact with the justice system. Other vulnerable groups include homeless youth and victims of sex trafficking. They face survival challenges "on the street" and increased risk of involvement with law enforcement.

This discussion will focus on juveniles with justice system involvement. Based on the data available, it is difficult to estimate how many are in need of mental health or substance use services. However, experience at the community level suggests that the behavioral health needs of this population are considerable and many are likely to be underserved, unserved, or undiagnosed. At a minimum, needs for substance use treatment may be indicated by the data showing that one-sixth of all juvenile arrests are for offenses involving drugs or alcohol. Many others have committed offenses while impaired by alcohol or drugs of abuse.

Several factors may contribute to the circumstances which lead to youth becoming involved with the justice system, and other consequences that follow.

A recent report states that "the vast majority, between 75 and 93 percent of all youth entering the justice system are estimated to have experienced previous trauma."[22] Even more shocking, "girls in the justice system are 200 – 300 times more likely to have experienced sexual or physical abuse in the past than girls not in the justice system." [23]

The 2016 California Children's Report Card[24] defines one particularly vulnerable group as "crossover youth" (or multi-system users), because they have a history involving both the child welfare and juvenile justice systems. Often these children and youth have had multiple episodes of trauma or other severe adverse life experiences such as child abuse, profound neglect, or witnessing violence in their home or neighborhood. Parental abuse or neglect may have resulted in the child's placement in foster care or a group home, which is intended to provide for safety and well-being. In addition, the experience of removal from one's home is highly traumatic and the foster home may or may not be able to fully meet the child's needs. Studies show that these "youth are more than two times as likely to be incarcerated for low-level offenses than their justice-involved peers who are not involved in the child welfare system."

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[22] Erica Adams, "Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense." Justice Policy Institute, July 2010. http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf

[23] D. K. Smith, L. D. Leve and P. Chamberlain, "Adolescent Girls' Offending and Health-Risking Sexual Behavior: The Predictive Role of Trauma." *Child Maltreatment 11.4* (2006):346-353. Print,

[24] Website: **www.ChildrenNow.org**, see report: California Children's Report Card, 2016.

The childhood experience of trauma may lead to poor emotional regulation, emotional outbursts, or disruptive behaviors in schools. Such events, in turn, can set the stage for suspension, expulsion, or other disciplinary actions in schools. Disruptive behaviors left untreated may progress to events which lead to justice system involvement. Trauma-informed strategies may better serve the needs of youth by diverting them to therapy instead of punishment or incarceration.

Historically, "students of color, LGBT students, and students with disabilities…are disproportionately impacted by suspension and expulsion."[25] Across all age groups, for similar low-level offenses, persons of color are more likely to be incarcerated and much less likely to be referred to therapy, diversion, or probation than are their white counterparts. Research shows that African American children and youth are more than twice as likely to be incarcerated for non-violent offenses compared to white youth. Thus, as a matter of equity (or fairness of access), we should consider strategies to engage youth of color in mental health and substance use treatment and diversion.

Many serious challenges are faced by justice-involved youth. The most serious are those facing incarcerated youth; they report considerable despair and suicidal ideation.

One major risk for incarcerated youth is suicide.

- One national study* reported that approximately 10 percent of juvenile detainees had thought about suicide in the prior six months.
- About 11 percent of detained juveniles had previously attempted suicide.
- The rates of completed suicides for incarcerated juveniles are between two and four times higher than for the general population.
- The general population rate of completed suicides was reported in 2010 as 10.5 per 100,000 adolescents.

*K.M. Abram, J.Y. Choe, J.J. Washburn et al., "Suicidal Thoughts and Behaviors among Detained Youth," July 2014 Juvenile Justice Bulletin, pages 1-12.

[25]"Racial Disparities in Sentencing." American Civil Liberties Union, 27 Oct. 2014. https://www.aclu.org/sites/default/files/assets/141027_iachr_racial_disparities_aclu_submission_0.pdf; and Soler, Mark, "Reducing Racial and Ethnic Disparities in the Juvenile Justice System." Center for Children's Law and Policy, 2013. http://www.ncsc.org/~/media/Microsites/Files/Future%20Trends%202014/Reducing%20Racial%20and%20Ethnic%20Disparities_Soler.ashx/

In California, how many persons under 18 have contact with the justice system each year? The following table shows 2014 juvenile arrest numbers[26] for misdemeanors, felonies and status offenses. "Status offenses" are those which would not be crimes for adults, e.g. truancy, runaway, breaking curfew, etc. Additionally, unknown numbers of youth are counseled and released to a parent or guardian without formal arrest.

Table 3. Numbers[27] and Types of Juvenile Arrests, California, 2014

Total population[28] age 10-17	4,060,397	100 % of age 10-17
Total juvenile arrests	86,823	2.1 % of those aged 10-17
Status offenses	10,881	12.5 % of juvenile arrests
Misdemeanor arrests	48,291	55.6 % of juvenile arrests
Misdemeanor alcohol or drug:	9,676	20.0 % of misdemeanor arrests
Felony arrests	27,651	31.8 % of juvenile arrests
Felony drug arrests	3,058	11.1 % of felony arrests
All drug or alcohol arrests (misdemeanors & felonies)	12,734	14.7 % of all juvenile arrests

These data can paint only a partial picture of the justice-involved juvenile population. Data are often lacking on who, how many, or what percentage may need behavioral health services. One goal of this discussion is to identify strategies which reach out to youth from all backgrounds. The desired outcomes are to engage individuals in treatment and diversionary programs, and to avoid detention, whenever possible.

Addressing this topic may involve challenges in seeking information from other county agencies such as Juvenile Probation. Besides county departments of behavioral health, other limited funding sources for services may include: Juvenile Justice Crime Prevention Act, Youthful Offender Block Grant, SAMHSA-funded grants, City Law Enforcement Grants, Mentally Ill Offender Crime Reduction (MIOCR) Grant Program, Proposition 63 funds (MHSA), or Re-alignment I and II funds.

[26]Data are from: www.kidsdata.org, based on compilation of data from California Department of Justice records for 2014 juvenile arrest data. Total numbers of arrests declined in 2015 to 71,923, but overall percentages broken down by type of offense were similar to those for 2014.

[27] Percentages may not add to 100% due to rounding effects. Data are from California Department of Justice reported in 2015.

[28]CA Department of Finance, Report P-3, December 2014

Data shown below:

Recent county-level arrest data are not available to us for all types of juvenile offenses. However, we present the number of felony arrests for your county,[29] keeping in mind that these comprise only 31 % or about one-third of all juvenile arrests.

For state of California: **27,651 juvenile felony arrests, 2014.**

For your county: San Bernardino **2,251 juvenile felony arrests, 2014.**

QUESTION 6A:

Does your county provide mental health or substance use disorder treatment services or programs to justice system-involved juveniles while they are still in custody? Yes X No___.

If yes, please list briefly. Please indicate (if available) the main funding[30] sources for these programs.

PROGRAM: **FUNDING SOURCE:**

The SB-DBH programs designed to outreach to justice-system involved youth are grouped by funding source, in the table below.

[29] County-level data are from www.KidsData.org, a program of Lucile Packard Foundation for Children's Health.
[30] This question is asking for only the main funding sources to highlight some of these programs and their successful implementation. We recognize that counties often weave together funding from different resources. If this information is not readily available, please enter N/A.

PROGRAM:	FUNDING SOURCE:
Forensics Adolescents Services Team (FAST): - ADC Psychoeducation and referrals - Suicide Risk Evaluations - Crisis Intervention - Clinical Assessment within 14 days of detainment for all youth - Brief psychoeducational based treatment - Medication Support Services - Collateral contact with Parents/Guardians - Referrals to Juvenile Justice Community Reintegration (JJCR) - MDT and Individualized Treatment Plans - Training for Probation staff - Substance Abuse/Use education and referrals to community based SUD services upon release - Screenings and referrals to Juvenile Drug Court - Screenings and referrals for higher level SUD residential treatment - Trauma Resiliency Model (TRM) - Participate in Child and Family Team Meetings (CFT) of Probation youth who are pending placement - Mental Health Liaison for the 241.1 Committee	1991 Realignment
Gateway: - Moral Reconation Therapy (MRT) - NA/AA Meetings - Individual drug and alcohol services - Screenings and referrals for higher level SUD treatment residential	Probation

In addition to these programs, suicide prevention efforts by Probation and FAST are of note since incarcerated youth are at a high risk for suicide. Every detained youth takes the Massachusetts Youth Screening Instrument version 2 (MAYSI-II) upon detainment, and Probation immediately reviews the scores of this inventory. There are five specific questions regarding suicide, and if a youth endorses two of the five, they are automatically placed on a 10-minute suicide watch called a Suicide Observation Status (SOS-I). If a youth endorses three of

the five, they are automatically placed on a SOS-II which is a 5-minute Suicide Observation Status. In addition, FAST reviews the MAYSIs daily of all youth who were booked into the JDAC and will determine if a youth needs to be assessed that day, within 3 days, or within 14 days, depending on the answers to the screening questions and their interview with the nurse during this pre-physical screening. Finally, all staff working within the JDACs receive 8 hours of Suicide Awareness training during their orientation period and a two hour refresher course every year.

QUESTION 6B:

Are the mental health and substance use services provided to non-custodial youth involved with probation or diversion programs different from those services provided to youth in the general community? Yes X No___

If yes, please list briefly. Please indicate (if available) the main funding source for these programs/services.

PROGRAM: **FUNDING SOURCE:**

SB-DBH has specific interventions and services for youth who are involved with Probation in order to meet the specific needs of this population. The table identifying the programs and the funding sources is included below.

PROGRAM:	FUNDING SOURCE:
Integrated New Family Opportunities (INFO) – Justice-Involved Youth Only ☐ Intensive Probation Supervision ☐ 24/7 Case Management ☐ Functional Family Therapy (FFT) ☐ Moral Reconation Therapy (MRT)	MHSA – CSS, Medi-Cal, and EPSDT
Juvenile Justice Community Reintegration (JJCR) – Justice-Involved Youth Only ☐ Moral Reconation Therapy (MRT) ☐ Participates in the following Specialty Courts – MDT Participation through Juvenile Mental Health Court (JMHC), Court for Individualized Treatment of Adolescents (CITA) and Juvenile Drug Court (JDC)	SAMHSA, 1991 Realignment, Medi-Cal and EPSDT

Coalition Against Sexual Exploitation (CASE) • Social Worker II and Alcohol and Drug Counselor are part of a multidisciplinary team (MDT) that meets weekly to discuss cases of youth who are currently being exploited or at risk of sexual exploitation. The CASE team includes staff from: Children's Network, SB-DBH, CFS, Probation, Public Health and the Public Defender's office.	MHSA - PEI
Juvenile Drug Court Treatment Program	Youth Block Grant
Success First/Early Wrap	MHSA – CSS: C-1 Full Service Partnership Program with EPSDT Medi-Cal
Wraparound	MHSA – CSS: C-1 Full Service Partnership Program with EPSDT Medi-Cal. Implemented in conjunction with Child and Family Services (CFS) and Probation.
Children's Residential Intensive Services (ChRIS)	MHSA – CSS: C-1 Full Service Partnership Program with EPSDT Medi-Cal. Implemented in conjunction with Child and Family Services (CFS) and Probation.

QUESTION 6C:

Do any of these programs engage the parents/guardians of juveniles involved with the justice system?

Yes X No___. If yes, please list briefly.

The following SB-DBH programs engage parents and guardians accordingly:

1. The Forensic Adolescent Services Team (FAST) attempts to contact the parents/guardians of all youth to obtain bio/psycho/social information on the youth when completing the initial clinical assessment, when a youth is first placed on a Suicide Observation Status (SOS) and to involve them when there is a special multi-disciplinary

team that is held regarding their child. FAST also participated in children and family teams for detained Probation youth who are currently waiting for placement.

2. The Gateway program is for all youth who have family engaged in their treatment. This program includes weekly family therapy to assist with the transition of the youth back into the community upon release from the 18-month long program. Gateway is a residential program that provides rehabilitation services to youth who are committed to the program by the Juvenile Court. Gateway provides 24-hour supervision for male juveniles between the ages of 16 and 19, and has a bed capacity of 40 wards.

3. Integrated New Family Opportunities (INFO) and Functional Family Therapy (FFT) is an evidenced based model that treats the entire family. Minors and families are enrolled in the program for approximately three to six months. During this time, they receive FFT for approximately 12 to 14 weeks, Moral Reconation Therapy (MRT) through completion of Step 12, and substance cessation support and aftercare services. Intensive Probation supervision is maintained during the three to six month enrollment, but is generally decreased as the minor and family become a cohesive, functional family unit and are less dependent upon the INFO team. Due to intensity of Functional Family Therapy (FFT) and Intensive Probation Supervision, small caseloads have been found to be most effective for ensuring program integrity. Staff includes peer and family advocates available to work with the youth, parents, and family providing resources and referrals to other need services.

4. Juvenile Justice Community Reintegration (JJCR) staff participate in the three specialty courts and require parental involvement. Staff work with the families to link youth to services and the parents to NAMI and/or a family resource center. JJCR works with the minor while still detained. The family and minor are consulted regarding the minor's history, strengths, and needs, as well as the family's unique circumstances. Aftercare programs are sought to support the minor's smooth transition into the community. A PFA is available to work with the youth, parents, and family providing resources and referrals to other needed services.

5. Family support systems are welcome to participate in the intake and admission process of all programs, if clinically appropriate and welcomed by the youth. Services provided as part of a youth's treatment episode includes components of individual family counseling, multi-family groups, and parental education sessions as clinically appropriate and specified in the treatment plan. Youth are encouraged and assisted in developing family/support systems as clinically appropriate. For the Juvenile Drug Court Treatment Program the youth's family/support system is not required to attend court sessions with the youth, but they are highly encouraged to attend and participate.

6. Success First / Early Wrap (SF/EW) is a MHSA funded Full Service Partnership, serving children, youth, and families throughout San Bernardino County who are not eligible for the Wraparound Program. The target population for services is children and youth who struggle with emotional disturbances and co-occurring disorders and whose family income is 200 percent or less of the federal poverty level. Services are time-limited (i.e., 4 month program with monthly extensions up to 6 months) and will be delivered in the home or in community settings convenient for the families. The time-limited nature of the program is intended to facilitate rapid change and stabilization of the child and family.

7. Wraparound is a program collaboratively implemented by DBH, Child and Family Services (CFS), and Probation to reduce the risk of out-of-home placement and recidivism by bringing individuals, agencies and the community together as the decision making team with the central focus being to meet the needs of the child and family. The Wraparound family actively participates in identifying their strengths and needs. Individualized services and supports (both formal and informal) are then developed and provided to meet each of the identified needs. The Wraparound paradigm allows for the adoption of the Core Practice Model while continuing to provide a highly supported treatment paradigm. The integration of Intensive Care Coordination and Intensive Home Based Services within the Wraparound paradigm allows for the focus on strengths building and skills acquisition experiences, while shifting away from traditional, professional-driven service delivery focusing on family deficits and only inadequately emphasizing family strengths.

8. Children's Residential Intensive Services (ChRIS) is a MHSA Full Service Partnership program implemented by DBH in close collaboration with Child and Family Services (CFS) and Probation. ChRIS agencies are mental health clinics which are part of group homes utilized by CFS and/or Probation to meet the residential needs of their dependents and wards. These group homes function with two independent contracts, one with DBH for mental health services and one with the placing agency. Children and youth requiring residential care are in need of a multi-faceted approach of care. Although the precise requirements for service provision may be different for dependents and wards, ChRIS program services are provided within the context and implementation of a Full Service Partnership (FSP) which utilizes the Core Practice Model (CPM) as defined by DHCS.

MENTAL HEALTH SERVICES ACT (MHSA) PROGRAMS HELPING CHILDREN AND YOUTH RECOVER

California voters passed the Mental Health Services Act (MHSA) in November, 2004 to expand and improve public mental health services. MHSA services and programs maintain a commitment to service, support and assistance. The MHSA is made up of the five major components described below:[31]

- **Community Services and Supports (CSS)**—provides funds for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are in this category; FSPs provide wrap-around services or "whatever it takes" services to consumers. Housing is also included in this category.
- **Capital Facilities and Technological Needs (CFTN)**—provides funding for building projects and increasing technological capacity to improve mental illness service delivery.
- **Workforce, Education and Training (WET)**—provides funding to improve and build the capacity of the mental health workforce.
- **Prevention and Early Intervention (PEI)**—provides a historic investment of 20% of Proposition 63 funding to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.
- **Innovation (INN)—**funds and evaluates new approaches that increase access to the unserved and/or underserved communities; promotes interagency collaboration and increases the quality of services.

Prevention and Early Intervention (PEI) Programs and Services

Twenty percent of MHSA funds are dedicated to PEI programs as an essential strategy to "prevent mental illness from becoming severe and disabling" and to improve "timely access for under-served populations." PEI programs work to reduce the negative outcomes related to untreated mental illness, including suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes.[32] Counties must use at least 51% of PEI funds to serve individuals 25 years of age and younger, according to the regulations (Section 3706). These programs provide for outreach, access and linkage to medically necessary care.

[31] Mental Health Services Oversight and Accountability Commission, December 2012. "The Five Components of Proposition 63, The Mental Health Services Act (MHSA) Fact Sheet." http://mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_FiveComponents_121912.pdf

[32] Mental Health Services Oversight and Accountability Commission, December 2012. "Prevention and Early Intervention Fact Sheet: What is Prevention and Early Intervention?" http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_PEI_121912.pdf

Prevention of Suicide and Suicide Attempts

Public health data for California and the U.S. show that there are risks for suicide for multiple age groups and race/ethnicity populations. In particular, youth suicide and suicide attempts are serious public health concerns. Suicide is the second leading cause of death among young people ages 15-19 in the U.S., according to 2013 data.[33] Males are more likely to commit suicide, but females are more likely to report having attempted suicide. A recent national survey found that nearly 1 in 6 high school students (~17%) reported seriously considering suicide in the previous year, and 1 in 13 (or 7~8%) reported actually attempting it.[34]

The risks for youth suicide and suicide attempts are greatly increased for many vulnerable populations: foster youth, youth with disabilities, those who face stressful life events or significant problems in school, incarcerated youth, LGBTQ youth, and individuals with mental illness or who experience substance abuse. Among racial and ethnic groups nationwide, American Indian/Alaska Native youth have the highest suicide rates. Research confirms that LGBTQ youth are more likely to engage in suicidal behavior than their heterosexual peers.[35] Attempting to address the problem of youth suicide is both daunting and complex due to the diversity of needs and potential contributing factors for different individuals, including family history of suicide or exposure to the suicidal behavior of others. Below, we show the number of youth suicides per year by age group to gain perspective on the size of this problem in California.[36]

Table 4. California: Numbers of Youth Suicides by Age Group, 2011-2013.

California	Number		
Age	2011	2012	2013
5-14 Years	28	19	29
15-19 Years	163	129	150
20-24 Years	271	282	302
Total for Ages 5-24	462	430	481

[33] Child Trends Databank. (2015). Teen homicide, suicide, and firearm deaths. Retrieved from: http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths.
[34] Centers for Disease Control and Prevention. (2015). Suicide prevention: Youth suicide. Retrieved from: http://www.cdc.gov/ViolencePrevention/pub/youth_suicide.html.
[35] Marshal, M.P., et al. (2013) Trajectories of depressive symptoms and suicidality among heterosexual and sexual minority youth. Journal of Youth and Adolescence, 42(8), 1243-1256. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articales?PMC3744095/
[36] http://www.kidsdata.org , topic: suicides by age group and year in California.

By comparison, the number of youth suicide attempts is difficult to determine because they are combined with hospital data for self-injury. In California there were 3,322 hospitalizations for self-injury reported during 2013 for those age 24 and younger. Estimates vary, but slightly less than half of self-injury events (e.g. about 1,660) may have been suicide attempts. As with the data for suicide deaths, these numbers should be viewed with a degree of critical skepticism. Actual intent may not be readily ascertainable due to insufficient evidence, privacy concerns, or reticence of loved ones. There also may be delays in reporting or under-reporting to the state.

Reports of suicidal ideation are much more common and show that much larger numbers of youth are at risk. As an example, we may consider data for the population of high school-age young people which was about 2.1 million in 2014 for California. That means there are between 500,000 and 530,000 individuals eligible for each of the four years of high school (based on ages). Not all members of these age groups are in school, but those not in school are also at risk.

Survey data (below) show the percentage of public high school students who reported seriously considering attempting suicide in the prior 12 months in California. [37]

Table 5. Public High School Students Reporting Thoughts of Suicide, 2011-2013

California	Percent	
Grade Level	Yes	No
9th Grade	19.3%	80.7%
11th Grade	17.5%	82.5%
Non-Traditional	19.4%	80.6%
All	18.5%	81.5%

Data from your county are shown on the next page (if available).[38] Some counties or school districts either did not administer the surveys or else did not report their results.

[37] **Data Source:** California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). The 2011-2013 period reflects data from school years 2011-12 and 2012-13. District- and county-level figures are weighted proportions from the 2011-13 California Healthy Kids Survey, and state-level figures are weighted proportions from the 2011-13 California Student Survey.

[38] Source of data: http://www.kidsdata.org, topic: suicidal ideation by grade level, in California. Note on abbreviations: N/D = no data; N/R=not reported.

San Bernardino County:

Table 6. Percent of High School Students Reporting Thoughts of Suicide, 2011-13

Suicidal Ideation (Student Reported), by Grade Level: 2011-2013		
Grade Level	**Yes**	**No**
9th Grade	N/R	N/R
11th Grade	N/R	N/R
Non-Traditional	N/R	N/R
All	N/R	N/R

N/R = too little data was collected for valid reporting, or the survey data were not submitted to the agencies or contracted entities who perform the analysis (CA Department of Education, CA Healthy Kids Survey, or WestED, etc).

QUESTION 7A:

Does your county have programs that are specifically targeted at preventing suicides in children and youth under 16 (ages 6-16) in your community?

Yes X No_____ If yes, please list and describe very briefly.

SB-DBH has a variety of programs to prevent suicide in children and youth:

1. The Student Assistance Program in partnership with the San Bernardino County Superintendent of Schools (SBCSS) implements the Positive Behavioral Interventions and Support (PBIS) in 13 school districts totaling 153 local schools sites throughout the county. In the next year, 30 additional schools will begin to implement PBIS through partnerships with DBH. Many other schools and districts implement PBIS or similar programs themselves or through other partnerships. The SBCSS plans and implements trainings that address the individual needs of school districts and sites to have the largest impact on the students they serve. PBIS is a systems-based, multi-tiered, evidence-based framework for establishing the social culture and behavioral supports needed for children in a school to achieve both behavioral and academic success, which helps identify and reduce suicide risk. In addition to PBIS, the Student Assistance Program also provides trainings to schools and mental health providers to reduce risk factors and increase protective factors.

2. The Community Crisis Response Team (CCRT) offers mobile response to a call indicating that there is a minor in psychiatric crisis and goes to schools, group homes, foster homes, private homes, and other areas of the community. Triage Engagement and Support Teams (TEST) also respond with law enforcement to calls related to children and

adolescents experiencing a mental health crisis. Both teams attempt to prevent avoidable hospitalizations, manage stressful family dynamics, and coordinate and manage linkages to resources that assist in maintaining minors in least restrictive setting.

3. SB-DBH Public Information Office (PIO) is involved with "Directing Change," which involves teens creating brief films educating youth on depression and suicide. This is a powerful program and culminates in an event involving students from all over the Inland Empire with prizes and film showings, showcasing creativity and important information for youth.

4. The SB-DBH partnership with the California Mental Health Services Authority (CalMHSA) has enabled us to implement several suicide prevention efforts throughout the county. The campaign labeled "Know the Signs" is a statewide media campaign that offers education and outreach to all residents that are experiencing thoughts of suicide and also those who may know someone who is at risk of suicide. Through the statewide program and film contest called Directing Change, we are able to engage youth and young adults in creating 60 second public service announcements on suicide prevention. These films are used in many of our outreach efforts with students and young adults in our community and assist in facilitating important conversations with youth about suicide and recognizing the signs of a peer that may be struggling with thoughts of suicide.

5. In addition, SB-DBH have staff and community partners that have been trained to deliver evidence-based suicide prevention strategies, such as ASIST (Applied Suicide Intervention Skills Training), safeTALK, suicideTALK, Mental Health First Aid, and Cognito to the community members, students and school staff. Trainings are offered in all areas of the county as needed and are helping build the capacity of our suicide prevention efforts. SB-DBH conducts suicide prevention presentations throughout the community to create awareness surrounding the services and programs that are available in our county for those that are experiencing thoughts of suicide or are having suicidal ideations.

QUESTION 7B:

Does your county have programs that are specifically targeted at preventing suicides in transition aged youth (ages 16-25) in your community?

Yes X No_____ If yes, please list and describe very briefly.

SB-DBH has specific programs to prevent suicide in youth ages 16-25:

1. The Community Wholeness and Enrichment program provides various evidence-based suicide prevention trainings that include suicideTALK, safeTALK and Applied Suicide Intervention Skills Training (ASIST). suicideTALK prepares community members of all ages, including youth, to intervene with persons at risk of suicide. safeTALK provides individuals over the age of 16 (and as young as 15) with community resources and information on how to connect someone with thoughts of suicide to further help. It prepares participants to recognize the signs and respond appropriately to them and over the past year, 13 community members participated in a safeTalk training. The ASIST teaches participants age 16 years and older to intervene when someone may have thoughts of suicide. ASIST is a more advanced training where participants gain greater insight to attitudes, aspects, and views surrounding suicide and learn how to create an individualized suicide safety plan for persons at risk and 120 people were trained in ASIST in the past year.

2. The Military Services and Family Support program engages transition-aged youth in schools and college campuses throughout the region. Presentations on suicide awareness along with available resources are given frequently. Additionally, through prevention and early intervention services, transition-age youth are provided with support, counseling, and education to reduce the risk factors associated with suicide.

3. The Community Crisis Response Team (CCRT) offers mobile response to a call indicating that there is a minor in psychiatric crisis and goes to schools, group homes, foster homes, private homes, and other areas of the community. Triage Engagement and Support Teams (TEST) also respond with law enforcement to calls related to children and adolescents experiencing a mental health crisis. Both teams attempt to prevent avoidable hospitalizations, manage stressful family dynamics, and coordinate and manage linkages to resources that assist in maintaining minors in least restrictive setting.

4. The TAY Center is a program aimed at the 16-25 age population, creating a safe place for young adults to receive socialization, mental health intervention and stabilization. Mental health staff are trained in suicide risk assessments and screen for risk of suicide, as appropriate. SB-DBH has a TAY-specific co-located short term crises residential program named STAY, which is a comprehensive multidisciplinary program. It can serve as a step-down from psychiatric hospitalization and helps ensure appropriate follow-up care.

QUESTION 7C:

Do you have any further comments or suggestions regarding local suicide reduction/prevention programs?

Yes X No_____. If yes, please list briefly.

SB-DBH has a few other outreach strategies to share as suggestions and strategies for local suicide reduction and prevention programs:

1. SB-DBH offers the ASIST and safeTALK educational trainings to our staff and community members as well. The education sessions are presented in various locations across the County and include people that work in crisis services, the justice system, law enforcement, education, hospitals, other county agencies, homeless services, faith-based organizations, alcohol and drug services, community based organizations, and veteran organizations. Multiple communication channels are used to advertise the education sessions, including web blasts, a listserv, electronic mail invitations to contract providers, and SB-DBH social media accounts. The overarching goals of the educational sessions are to provide information on how to understand mental health concerns and link individuals and organizations to resources based on the individual's needs.

2. Education is key and provides a proactive pragmatic approach to children and adolescents experiencing depression, anxiety and any other mental health symptoms. A creative approach could be school-based counseling groups to provide information as well as offer some creative activities for children and adolescents to learn to identify their symptoms and learn some coping skills to manage the symptoms. This would also identify minors that are in need of intensive mental health services, and provide family contact and linkage to resources. More collaboration with schools where SB-DBH could provide presentations and activities for students could be a goal for the upcoming year, which will also help build relationships and alliances.

3. The department is committed to providing services such as the Crisis Walk-in Clinics, the Community Crisis Response Team, and supporting web based resources: Know the Signs, Each Mind Matters, and My3 Mobile App and recommend these as best practices.

Early Identification of Risks for First-break Psychosis

Sometimes, unfortunately, the first major indication parents may have about first break psychosis in a child or youth may be changes in behavior, including an unusual drop in school grades, experimenting with substance abuse, running away, or behavior that gets the attention of the justice system. PEI programs for children and youth have a goal of identifying such persons early so that they receive appropriate services.

In California, many MHSA -funded programs provide these services. Thus far, the research and evidence for improved outcomes is solid enough to support these major efforts at both the state and national level. Therefore, now there are also federal funds from SAMHSA designed to intervene early to target first-break psychosis and provide a level of coordinated care and treatment that is effective. Some counties braid together funds from more than one source to support these programs and services.

Our questions address early intervention programs, regardless of funding source.

QUESTION 8A:

Does your county have services or programs targeted for first break psychosis in children and youth, and transition aged youth (TAY)?

Yes X **No____**

Programs within SB-DBH are designed to meet the level of need experienced by a child or youth, not a specific symptom. For example, the Children's Intensive Services (CIS) program is designed to help children and youth who have either recently experienced a psychiatric hospitalization or are at risk for being hospitalized. Nine percent (9%) of the youth served in CIS in FY 15/16 needed help with psychosis. This may not represent a true first break, as that typically implies the beginning of a long-term struggle with a serious and persistent mental illness. However, the CIS program is structured to help families cope with psychosis. Other intensive children's programs (e.g., Success First/Early Wrap, Children and Youth Collaborative Services (CYCS), and Therapeutic Behavioral Services (TBS)) are also available to help these youth and approximately 5% - 6% of the youth served by these programs are coping with psychosis.

The ACE (Assessment, Coordination, and Engagement) staff are trained upon intake to appropriately assist transition-aged children and youth by connecting them to the care they need, especially in the case of first-break psychosis. SB-DBH community mental health clinics are also involved in serving youth having to cope with psychosis. In FY 15/16, 11% of the youth served by these clinics had symptoms of psychosis. However, the primary program serving this

population is our Transitional Aged Youth (TAY) Centers. Thirty-five percent (35%) of the consumers served through the TAY programs are coping with psychosis.

Both the Community Crisis Response Team and TEST are field based programs aimed at providing crisis intervention in the community. CCRT serves a large number of minors experiencing a psychiatric crisis and offers assessment for acuity and linkage to outpatient services or hospitalization for stabilization. In a situation with a minor experiencing a first break psychosis, there is education and support given to the parents/guardians/care givers. TEST responds to referrals from CCRT or any TEST co-location site such as law enforcement or California State University San Bernardino Counseling Center for follow up treatment and case management following a crisis situation to ensure minors are linked to medication and other behavioral health services.

QUESTION 8B:

If yes, please list by age range(s) targeted and describe the program or services briefly. Also, please include the major funding source, (i.e., MHSA, SAMHSA Block Grant, Realignment I/II, Medi-Cal, etc), if the information is readily available.

Age Range	Service	Funding Source
Children Age 0-18	Children's Intensive Services (CIS) targets 0-18, and may serve youth up to 21 years of age. Intensive home and community based services are provided.	Funding is 100% EPSDT Medi-Cal with local match being provided by 1991 realignment.
	Success First/Early Wrap is a wrap-informed FSP designed to function as a Core Practice Model (CPM) program targeting children and youth, but serving youth up to 21 as needed.	Funding is a combination of EPSDT Medi-Cal and MHSA, with the MHSA funds utilized for both the local match and additional Mode 60 activities.

Children Age 0-18	Therapeutic Behavioral Services (TBS) is a free standing program designed to provide TBS and Intensive Home Based Services (IHBS) to children and youth being served by a separate Specialty Mental Health Provider (SMHP). TBS targets children and youth aged 0-21. In FY 16/17, this program was incorporated into Comprehensive Children and Family Support Services (CCFSS), a child FSP, in order to make IHBS more available to children and youth served throughout the county.	Prior to FY 16/17, funding was 100% EPSDT Medi-Cal with local match being comprised of realignment funds. As of FY 16/17, MHSA funds are providing the local match for the increased amount needed to facilitate IHBS for agency not designed to provide such intensive coaching activities.
	CYCS is the centralized children's program and the Centralized Children's Intensive Case Management Services (CCICMS) unit is designed to aid children and youth who do not appear to be well connected to, or benefiting from, other programs within the system of care.	CCICMS is funded via EPSDT Medi-Cal, realignment, and MHSA as an outreach and engagement program under Comprehensive Children and Family Support Services (CCFSS).
Youth Age 6-18	A First Break program was included and approved as an expansion of the PEI Community Wholeness and Enrichment program in 2010. Due to funding restrictions, this program has not yet been implemented. SB-DBH is taking steps to prioritize and implement this program during the FY17/18 fiscal year.	The program will be primarily funded via MHSA-PEI funding and Medi-cal. Services will be specialized toward this population and serve family members.
Preschool & School Age Youth 5 - 26	CCRT	MHSA funded program
Preschool & School Age Youth 5 - 26	TEST	SB82 grant funded program.

QUESTION 8C:

Do you have any further comments or suggestions about local programs targeted for first break psychosis in children and youth?

Yes X No____. If yes, please describe briefly.

In its future planning, DBH is considering expanding Prevention and Early Intervention to include services to individuals who are identified as experiencing the onset of a serious mental illness or emotional disturbance with psychotic features. This will include transition-aged youth and will be a part of the existing Community Wholeness and Enrichment program. Consumers and their families can be engaged in intensive therapeutic interventions for a maximum of up to 5 years per the Prevention and Early Intervention regulations approved on October 6, 2015. Additional services in this potential expansion could include assessments, individual and group therapy, medication, and multifamily psychoeducation groups.

Full Service Partnership (FSP) Programs for Children and Youth

Full Service Partnership programs (FSP) provide a broad array of intensive, coordinated services to individuals with serious mental illness. These may also be referred to as "wrap-around" services. The FSP program philosophy is to "do whatever it takes" to help individuals achieve their goals for recovery. The services provided may include, but are not limited to, mental health treatment, housing, medical care, and job- or life-skills training. Prior research has shown FSP programs to be effective in improving educational attainment, while reducing homelessness, hospitalizations, and justice system involvement. Such intensive services can be costly, but their positive impact and results outweigh the costs and actually produce cost savings to society.[39]

Overall, the data thus far indicates some very good news. These positive outcomes are leading to greater understanding of what works well for children and youth. We hope to increase resources to serve more children and youth in FSP programs.

Outcomes Data for Children and Youth (TAY) in FSP Programs

When a new client begins FSP services, data are collected to serve as a baseline for later comparisons. Next, data are collected from each client after one year of services and then again at two years. The outcomes data are calculated as a change from the number of events for each client in the year prior to beginning FSP services, compared to one year later (and again at 2 years, for TAY).

Children's FSP data are shown for only one year of service, because children usually experience more rapid improvements than do TAY or adults. Here, improved academic performance is defined and measured as the percentage of children who had improved grades relative to baseline academic performance prior to beginning FSP services.

Please examine the data in the following tables below taken from a report[40] by CBHDA released in early 2016. First, examine the statewide data for children (age 0-15) and TAY (age 16-25). Next, for each of these age groups, take note of which outcomes show improvement and those which may need further attention to improve services for client recovery and wellbeing.

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[39] Prop 63 Mental Health Services Oversight and Accountability Commission (MHSOAC). Evaluation Fact Sheet: "Full Service Partnership (FSP) Program Statewide Costs and Cost Offsets" http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_Eval5_FSPCostAndCostOffset_Nov2012.pdf

[40] Data reported from the new CBHDA-designed Measurements, Outcomes, and Quality Assessment (MOQA) data system for clients in FSP programs. http://www.cbhda.org/wp-content/uploads/2014/12/Final-FSP-Eval.pdf. Data from 41 counties were analyzed. We express great appreciation to CBHDA for sharing their data with the CMHPC.

Full Service Partnership Data for Children and Youth for Fiscal Year 2013-2014.

STATEWIDE DATA:
FSP Partners included in this analysis: 41 counties[41] plus Tri-Cities group reporting, Fiscal Year 2013-2014:

- Children (age 0-15): with at least one year of service.
- Transition Age Youth (TAY, ages 16-25): with 2 years or more of services.

Table 7. Children, ages 0-15.

N=5,335 completed at least 1 year of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 year	Change in Client Outcomes at 2 years
Mental Health Emergencies	89% ⇩	--
Psych. Hospitalizations	49% ⇩	--
Out-of-Home Placements	12% ⇩	--
Arrests	86% ⇩	--
Incarcerations	40% ⇩	--
Academic Performance	68% ⇧	--

The data the table above show that: overall, children experienced decreases in total numbers of mental health emergencies, hospitalizations, out-of-home placements, arrests and incarcerations. There was an increase in academic performance, as measured by the percentage of children who had improved grades relative to baseline during the year prior to beginning FSP services.

[41] Alpine, Butte, Colusa, Contra Costa, El Dorado, Fresno, Humboldt, Kern, Kings, Marin, Los Angeles, Mariposa, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter-Yuba, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo. Other counties do have FSP services but for technical reasons were not able to get the reports out of their data systems for this project.

STATEWIDE DATA (Fiscal year 2013-2014): continued below.

<u>Table 8. Transition Age Youth</u> (TAY) ages 16-25.

N= 4,779 completed at least 2 years of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 Year	Change in Client Outcomes at 2 years
Mental health emergencies	84% ⇩	86% ⇩
Psych. hospitalizations	41% ⇩	57% ⇩
Emergency shelter use	20% ⇩	53% ⇩
Arrests	81% ⇩	86% ⇩
Incarcerations	45% ⇩	49% ⇩

The data in the table above show that: overall, transition-aged youth experienced decreases in total numbers of mental health emergencies, hospitalizations, use of emergency shelters, arrests and incarcerations. These beneficial outcomes occurred by the end of the first year.

All of these improved outcomes continued and were sustained at the end of the clients' second year in FSP services. Two types of outcomes, psychiatric hospitalizations and use of emergency shelters, had improved even more by the end of clients' second year of FSP services, compared to the end of the first year.

The goal is to think about how the FSP outcomes data for children and youth may help inform your suggestions for improving local services or programs**.**

QUESTION 9A:

What are the most urgent child or youth problems in <u>your</u> county? (For example, homelessness, problems with school or work, arrests, incarcerations, use of emergency MH services or psychiatric hospitalizations, out-of-home placements for children, substance abuse, teen pregnancy/parenting, etc.).

The most urgent problems for child and youth in our county are:

Children Entering FSP:

1. *Family/Interpersonal Conflict:* During 2016, three out of every four children entering into Full Service Partnerships (FSPs) need help with family conflicts or interpersonal conflicts.

2. *School Problems:* Approximately 60% of children need help with their functioning in school. This is due to poor school achievement and/or problematic behaviors at school. FSP agencies report needing to help children and family cope with being suspended or expelled, and requiring rapid efforts to address the needs this creates.

3. *Danger to Self or Others:* Over 20% of children served through the FSPs are at risk for suicide. 1 out of every 4 children served are at risk for harming others in some manner. Some of these children are effectively helped through the FSP services only, but some require hospitalization or a crisis stabilization unit. They are able to utilize the county-wide crisis walk in centers, but there have been difficulties locating psychiatric beds. It is hoped that the crisis stabilization units currently being constructed will help with this issue.

4. *Family Support:* The parents and caregivers of families served through the FSPs face a variety of issues including, but not limited to: 41% struggle to provide the needed level of supervision given the child's behaviors; 59% need help in better understanding the child's behavioral health issues and how to address these; 36% report not having the social resources believed to be helpful with parenting a child needing this level of help; and 9% display an unstable living situation. This last concern has a huge impact on the ability of programs to assist, as having stable housing is a critical element in helping children recover and grow.

5. *Former System Involvement:* There are many minors aging out of the foster and probation systems with minimal to no support in accessing appropriate services and building life skills.

6. *Substance Use:* Substance use among youth usually impacts relationships, school, and can lead to incarcerations. With the advent of technology and the internet, access to legal compounds that can be combined to produce illicit drugs is easier than ever. Synthetic drugs on school campuses have become harder to identify as the illegal substances have been made to look like common snack foods. In 2014 SBC-DBH ADS entered into a Memorandum of Understanding (MOU) with the San Bernardino County Superintendent of Schools to arrange for the collection of California Healthy Kids Survey (CHKS) data to assist in identifying substance use by youth within communities in the county. This data will help define and target prevention efforts. SBC DBH ADS has received some of the preliminary data gathered by the 2015-16 surveys. Below are some of the treatment outcomes identified by the FY 15/16 surveys. This data can play a key role in determining where to focus prevention efforts because drug use at an early age is an important predictor of development of a substance use disorder:

Elementary School 5th Grade							
Have you ever drunk beer, wine or other alcohol?							
No	1,174	Yes, I drank one or two sips	190	Yes, I drank a full glass	9	No Response	91

Combined responses 7th, 9th and 11th grade:													
Past 30 days, used at least one drink of alcohol?													
0 Days	1,174	1 Day	925	2 Days	387	3-9 days	365	10-19 days	115	20-30 days	231	N/R	561
Past 30 days, used five or more drinks of alcohol in a row that is, within a couple of hours?													
0 Days	13,536	1 Day	313	2 Days	213	3-9 days	189	10-19 days	90	20-30 days	203	N/R	512
Past 30 days, used marijuana?													
0 Days	13,152	1 Day	361	2 Days	201	3-9 days	246	10-19 days	138	20-30 days	449	N/R	509
Past 30 days, used inhalants (things you sniff, huff, or breathe to get “high”)?													
0 Days	14,098	1 Day	111	2 Days	62	3-9 days	44	10-19 days	26	20-30 days	147	N/R	568
Past 30 days, used prescription pain medications to get 'high' or for reasons other than prescribed? (such as Vicodin™, OxyContin™, Percodan™, Ritalin™, Adderall™, Xanax™)													
0 Days	9,221	1 Day	140	2 Days	109	3-9 days	94	10-19 days	36	20-30 days	171	N/R	5,285
Past 30 days, used any other drug, pill, or medicine to get 'high' or for reasons other than medical reasons?													
0 Days	14,070	1 Day	124	2 Days	88	3-9 days	68	10-19 days	38	20-30 days	187	N/R	481
Past 30 days, used two or more substances at the same time? (for example, alcohol with marijuana, ecstasy with mushrooms)?													
0 Days	9,213	1 Day	144	2 Days	97	3-9 days	90	10-19 days	39	20-30 days	185	N/R	5,288

Additionally, in FY 15/16, among youth in San Bernardino County who entered substance use disorder treatment, 56% reported cannabis as being their primary drug of choice. The legalization of recreational marijuana presents challenges not only in San Bernardino County but throughout the state on educating youth of the dangers of marijuana. Marijuana will be more visible to youth as they may see their parents using

marijuana, which makes conveying dangers of use more challenging. Prevention efforts will have to be re-focused on this issue.

7. *Improved understanding of the LGBTQ youth population:* Part of the future of outreach to the LGBTQ is understanding this population within our larger SB-DBH population. SB-DBH implemented improved data collection in our demographic data as we work to appropriately collect data as to consumer's preferences. The department is still working on measures to collect data regarding the LGBTQ population. Several focus groups and guided discussions have been executed with department staff as well as with contract providers on developing an appropriate business process to collect sensitive data. LGBTQ subcommittee members have been present at planning meetings to advocate and subject matter expert feedback

8. *Homeless Services:* San Bernardino County of Schools, through McKinney-Vento Education of Homeless Children and Youth Assistance Act, identified over 30,000 school-aged children in School Year 14-15 (the most recent data available) as meeting the criteria for homelessness under the Act. While the children identified may not be literally homeless (no night time shelter) at the time of the survey, there is a higher than average risk of homelessness for this vulnerable population.

QUESTION 9B:

Do the FSP data suggest how (or where) improvements to certain services or programs could affect outcomes, and thereby help address the most urgent problems for children or youth in your community?

For FSP involved youth, one area of urgent need is finding employment resources for transition-aged youth (TAY). TAY have good outcomes due to program involvement for social and behavioral services like housing, reduced law enforcement involvement, and reduced psychiatric hospitalizations. Programs for supportive employment for TAY are needed. SB-DBH believes the model for this supportive employment program can be based on children's academic services, where success improves the longer youth are involved the program or the longer youth can access the supportive service. With children in FSP services receiving academic support, an average 12% increase in academic success is reported after the first year of involvement; by the second year, that increases to 68% over the baseline. Providing longer-term supportive employment and academic services for TAY youth may yield similar results.

Question 9C:

Do you have any other comments or recommendations regarding your local FSP programs or other types of "wrap-around" services?

Yes X No___. If yes, please describe briefly.

With the State Continuum of Care Reform (CCR) initiatives in children and youth services, the most urgent needs that will impact SB-DBH FSP programs and wrap-around services will be capacity. As detailed in early questions, SB-DBH is working with local school districts, hospitals, community partners, and our contract agencies to expand outpatient FSP capacity. With the needs of foster youth from other counties and the changes to the children and youth delivery system, SB-DBH will continue to identify and implement strategies in support of this reform.

One other area of focus for SB-DBH is the reality that 1 out of every 10 children served through the FSPs need help with some type of eating disorder. Agencies are reporting that the collaborative efforts to address this are effective, but utilize a much higher amount of staff time and resources. FSP dollars allow SB-DBH some flex funds to cover levels of care funded by Medi-Cal, such as partial hospitalization, but these funds are not a long-term strategy for addressing the needs.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Mental Health Planning Council. Questions below ask about operations of mental health boards, behavioral health boards or commissions, regardless of current title. Signature lines indicate review and approval to submit your Data Notebook.

(a) What process was used to complete this Data Notebook? Please check all that apply.

X MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

____MH Board completed majority of the Data Notebook

___ County staff and/or Director completed majority of the Data Notebook

X Data Notebook placed on Agenda and discussed at Board meeting

___ MH Board work group or temporary ad hoc committee worked on it

X MH Board partnered with county staff or director

___ MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

X Other; please describe:

The Behavioral Health Commission and the San Bernardino Department of Behavioral Health work in collaboration with County staff to research, discuss, provide data, and facilitate a comprehensive response to the questions posted in the Data Notebook.

(b) Does your Board have designated staff to support your activities?

Yes X No___

If yes, please provide their job classification:

- *One (1) Behavioral Health Director: Provides new member orientation upon appointment by the Board of Supervisors; participates in monthly sessions of Executive Committee and Board meetings or delegates staff to participate in her absence; provides regular updates on Federal, State, County and other policy issues.*
- *One (1) Executive Secretary II - Ensures Board meetings comply with Brown Act; notifies stakeholders of meetings; works with the Chair and Director to set monthly agendas; transcribes meeting minutes; schedules educational presentations and mandatory trainings.*

- *One (1) Office Assistant III - Assembles meeting binders; transcribes meeting minutes, arranges travel and reimbursement.*
- *Four (4) Secretary I – Provides support to District Advisory Committee (DAC) meetings; notifies stakeholders of meetings; transcribes minutes; schedules educational presentations.*

The Behavioral Health Commission would like it noted that under the direction and leadership of the Behavioral Health Director, Veronica Kelley, LCSW, DBH staff are extremely responsive to the commission's requests, such as educational presentations, attendance at conferences/trainings, and support at community events. Interaction with the Director and DBH staff includes information sharing, open dialogue and transparency.

In addition to the above, staff have worked hard to partner with Behavioral Health Commissioners to identify and quantify behavioral health outcomes on an ongoing basis so that meaningful analysis and conversations can take place throughout the year.

(c) What is the best method for contacting this staff member or board liaison?

Name and County: Raquel Ramos, Executive Secretary, San Bernardino

Email: rramos@dbh.sbcounty.gov

Phone #: 909-388-0801

Signature: _____

Other (optional): _____

(d) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: Raquel Ramos, Executive Secretary, San Bernardino

Email: rramos@dbh.sbcounty.gov

Phone #: 909-388-0801

Signature: _____

REMINDER:

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. We welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

For information, you may contact the email address above, or telephone:

(916) 327-6560

Or, you may contact us by postal mail to:

- Data Notebook
- California Mental Health Planning Council
- 1501 Capitol Avenue, MS 2706
- P.O. Box 997413
- Sacramento, CA 95899-7413